

**Professional Identity Development:
A Grounded Theory Study of Clinical Psychology Trainees**

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ABSTRACT

This is a constructivist grounded theory study of the impact of the clinical psychology flexible training scheme on the development of professional identity. Professional identity development involves the acquisition of new role behaviours and new views of the self. Research into professional identity development amongst clinical psychology trainees is scarce. Studies involving clinical psychology trainees have mainly focused on their psychological adaptation to the challenges of training.

A longitudinal study of the 2003 cohort of the University of Edinburgh Clinical Psychology Training Programme was conducted to identify factors that facilitate and impede professional identity development. A combination of focus groups and individual interviews were used to explore flexible trainees' experiences during their 4th and 5th years of training and the experiences of 4-year flexible and 3-year trainees in their first-year post-qualification. All interviews were transcribed and coded line-by-line in order to facilitate the development of analytic categories. Six main categories were identified: Perceived Competence, Formal Status, Comparisons of Self with Others, Expectations of Others, Role Conflict and Role Ambiguity.

The results suggest that professional identity development involves attaining equilibrium between the formal status of the role and the individual's perceived competence in that role. Role conflict, role ambiguity, comparisons of self with others and the expectations of others can all create a sense of disequilibrium and impede the individual's ability to identify with the professional role.

It would appear that flexible trainees are better able to identify with the professional role on qualification as they have greater opportunities to develop a sense of competence during their training in comparison with their 3-year peers. However, they also appear to experience greater conflict and ambiguity in their roles as flexible trainees, which has implications for their identity development during training.

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1. INTRODUCTION

This thesis explores the impact of the flexible training scheme on professional identity development amongst clinical psychology trainees. A longitudinal examination of the 2003 cohort, comparing and contrasting the experiences of flexible and 3-year trainees, aims to identify the factors that both facilitate and impede professional identity development. Whilst the focus is on trainees' experiences, these are interpreted with reference to the wider social, political and theoretical contexts.

The introduction begins with a review of the existing literature on professional identity development, to orient the reader to the theoretical context. This is followed by a more in-depth look at the profession of clinical psychology through an examination of its historical and political background and the impact these have had on its training programmes. The final sections focus on previous studies of professional identity development in clinical psychology and the factors influencing the development of this research project.

Professional identity development is a process that occurs over time throughout one's career and which changes and evolves in parallel with change and evolution within the profession itself. It can, however, be argued that the foundations of one's professional identity are formed during initial socialisation into the profession, which usually occurs during professional training. I therefore focus my literature review on studies of professional socialisation during training and present the theoretical context for this study in section 1.1.

Bucher and Strauss (1961) describe professions as systems of 'diversity and movement' which can be viewed as 'analogous to social movements' (p.332). Professions are not homogenous, as is assumed from a functionalist perspective; rather, there are 'segments' within professions which possess different central objectives, work activities,

methodologies and techniques. The conflict that these differences create acts as a catalyst for change. These *social movements* involve power struggles between different segments for a place within the institutional context in which the profession is situated. Clinical psychology has seen a number of such *social movements* since its development which have greatly influenced the nature of the profession today. The historical context of the profession of clinical psychology is outlined in section 1.2.

A profession's identity is dynamic and continually changing. Many of the changes that occur within professions are driven by the political contexts in which they are situated as well as by the profession's own objectives. Section 1.3 outlines the implications of the current political context for clinical psychologists.

It is important that training courses can adapt to the changing social and political context to reflect clinical psychologists' changing roles and to ensure that trainees are fit for purpose upon qualification. Section 1.4 outlines the current training context, including the necessary requirements for clinical psychology training and recent developments in training programmes.

There is a relative paucity of research into professional identity development amongst clinical psychology trainees, especially from trainees' perspectives. This thesis evolved from personal reflections on being a flexible trainee during a time of rapid expansion and change for the profession, which prompted the development of a pilot study and ultimately this thesis research. Section 1.5 outlines the research context, describing the current literature in this area, my personal reflections, the pilot study outcomes, and the current research questions.

Concluding the introduction, section 1.6 describes the personal context of this research to orient the reader to the researcher's beliefs, assumptions and expectations. I reflect on my own sense of professional identity and my expectations for the research in relation to these.

1.1. Professional identity development: the theoretical context

There have been numerous studies within the sociological literature on professional socialisation (Bucher & Stelling, 1977; Glaser & Strauss, 1971; Olesen & Whittaker, 1968). Glaser and Strauss (1971) describe this process as a *Status Passage* reflecting a move from one status to another, over time, within an organisation. This necessarily involves both changes in behaviour and in identity. A multi-dimensional view of professional socialisation, incorporating not only new role behaviours but new views of the self, is echoed by Olesen and Whittaker (1968) in their study of professional socialisation in nursing. They believe that these changing views of the self are directly related to external factors or particular objective events, which help shape the individual's changing self-concept.

The research described below approaches the study of professional socialisation from a symbolic-interactionist perspective whereby meaning emerges as a consequence of individuals' interactions with others and is dependent on their continual interpretation of these interactions. The symbolic-interactionist perspective has three important elements with reference to the study of professional identity development:

- Active construction by the individual (e.g. studentmanship, self-validation and selective role models).
- The importance of interaction with others and the meaning assigned to these interactions; (e.g. learning through the experience of working, value awarded to social practice, and feedback and validation from others).
- The influence of the context in which these interactions occur and the meanings they are awarded. The institution is a framework within which the individual chooses how to act based on the importance and meaning assigned to different cues (Conway, 1978).

The social environment and the individual's interactions with this environment are therefore central to the process of professional socialisation, in which the individual is an active participant. This framework considers professional identity development to be a process that is socially constructed rather than individually constructed where knowledge acquisition is dependent upon the context in which it occurs and the relations between individuals in this process (Eraut, 2000). The process of professional development, then, can be seen as 'more about *being* than *doing*':

Thus there is a subtle process of change at work as a trainee develops into a professional, a process which itself is more about being [italicised in original] than doing, and this progression may be enhanced by creating a favourable working environment. (Swanwick, 2005, p.862)

Becoming professional is not something that can simply be taught. It is a process in which the individual, their teachers and the environments in which they are learning and working, interact. Learning occurs out of opportunities to handle different experiences as they arise. The role of the teacher is to structure experiences rather than to transmit knowledge. Learning is therefore emergent and collaborative, not didactic (Dornan *et al.* 2005; Swanwick, 2005):

*Now the role of masters is to accept learners into their community of practice and help them construct a professional identity through social interaction with practitioners, peers and patients. (Dornan *et al.* 2005, p.170)*

Learning to become a professional thus involves being immersed in the professional context and having opportunities to assume the professional role. Many professional training courses are located within universities due to their role as the 'primary legitimating institutions' (Jackson, 1970, p.5). This, however, may not be the most appropriate way to meet the needs of the profession (Jackson, 1970). The contrast between the university and the professional's real world of work creates a dichotomy between theory and practice (Melia, 1987; Eraut, 2000). Trainees struggle to transfer

the theoretical based teaching they encounter at university to the fluid context of their day-to-day professional practice. Jackson (1970) therefore argues that:

The university's relationship is often partial in that there appears within the training programme itself a tension between the abstract intellectual training...and the instrumental needs of developing actual practitioners involving the awkward and necessary business of allowing the 'trained' candidate to come into contact with the object of the exercise. (p.5)

Role-playing and the opportunity to learn from experiences of working in the professional field are an essential part of the socialisation process (Bucher & Stelling, 1977; Gregg & Magilvy, 2001). Central to Bucher and Stelling's (1977) model of professional identity development is the attainment of a sense of mastery. Role-playing is crucial to this endeavour, as is a sense of autonomy and responsibility. The roles that trainees assume need to be seen as an important part of the professional role, which they judge by seeing other professionals engaging in this behaviour. An important function of 'role-play' is the ability to provide a valued contribution. If this is considered important then mastery and thus professional identity development will be enhanced. Increased participation in the profession also affords the opportunity for knowledge production, another essential component of professional identity development:

The practitioner's sense of identity as a master is enhanced as he or she offers graded contributions, from low to high accountability, and through being presented with work opportunities of increasing 'challenge and value' the individual develops a heightened sense of professional identity. (Swanwick, 2005, p.864)

Learning by doing is an important part of the process of professional identity development; however, it is not a sufficient condition in itself. It is also necessary to integrate the professional role into one's sense of self. Gregg and Magilvy's (2001) grounded theory study of professional identity development in Japanese nurses describes a circular process, which progresses in a spiral pattern. The process starts with *learning from working experiences*, which facilitates the development of the nurses' identities

along a number of different dimensions including: *recognising the value of nursing, establishing their own philosophy of nursing, gaining influences from education and a commitment to nursing*. The final stage in the establishment of a professional identity is *integrating nurse into self*. This reflects the multi-dimensional conceptualisation of professional socialisation incorporating new role behaviours with new views of the self.

One aspect of the self which changes throughout the socialisation process, and which seems to be important in the internalisation of the professional role, is beliefs about knowledge and attitudes to the uncertainty of knowledge (Lingard *et al.* 2003). These attitudes develop along a continuum from simplistic beliefs about knowledge as a certainty, to more sophisticated beliefs about knowledge as evolving and dependent on context. This often encompasses a move from focusing on one's own limitations of knowledge to the acceptance and understanding of limitations of knowledge within the field (Knight & Mattick, 2006; Lingard *et al.* 2003). Students therefore tend to see uncertainty as something to be avoided or disguised whereas their teachers accept uncertainty and find ways to deal with it.

In order to internalise the professional role, trainees seek confirmation from others in the form of feedback on their role performance and endorsement by others of their claims to be a professional (Olesen & Whittaker, 1968). Feedback from others can build confidence through fostering high self-esteem and drawing attention to aspects of performance which could be improved, both of which are important to developing mastery in the professional role (Eraut, 2000; Swanwick, 2005). Trainees, however, can be selective regarding the value they award to different role models, and they often emulate desired characteristics that they observe in several different people (Bucher & Stelling, 1977). They are selective about what they pay attention to in supervision, either discounting negative criticism on the grounds that they feel it is unimportant or questioning their supervisors' knowledge. Trainees become increasingly reliant on self-validation when assessing their own competence and award little value to formal methods of evaluation.

This reflects trainees' active participation in the construction of their professional identity observed by numerous authors (e.g. Cheshire, 2000b). Trainees are not passive recipients of a pre-determined identity; rather, they gain a sense of control over their activities by playing a part in constructing their own roles. Olesen and Whittaker (1961) termed this activity *studentmanship* which they define as 'a form of underground student behaviour that plays a prominent part in shaping interactional styles, operational values and staunchly held attitudes amongst students' (p.149) and which 'functions to suggest answers to a perpetually problematic issue: how to get through school, with the greatest comfort and the least effort, preserving oneself as a person, while at the same time being a success and attaining the necessities for one's future life'(p.150).

Difficulties in the development of professional identity can arise as a consequence of the individual's interactions with aspects of the profession's social structure. Kahn *et al.* (1964) termed two such consequences *role conflict* and *role ambiguity*.

Role conflict refers to the presence of competing demands on one's time and inappropriate demands given one's level of knowledge and skill. The consequences of *role conflict* are referred to as *role strain*, which can occur as a result of inadequate socialisation (Hardy, 1978). Conflicts are internalised resulting in 'anxiety, tension, frustration and a sense of futility' (Kahn *et al.* 1964, p.65). Additional consequences include: reduced job satisfaction; demoralisation as a result of loss of confidence; deterioration in attitudes towards the individual causing the conflict; deterioration in attitudes towards the job and the organisation as a whole; and increased propensity to quit (Ortquist & Wincent, 2006).

Role ambiguity occurs when one does not have adequate information to perform the role or to conform to the role expectations. Ambiguity can arise from a lack of information or information that is inadequately communicated. It may concern: not knowing the scope of one's responsibilities; not knowing how to fulfil one's responsibilities;

uncertainty as to whose expectations to meet; uncertainty around channels of communication; uncertainty around the consequences of actions; and uncertainty about how others view one's performance. The consequences of *role ambiguity* are similar to those of *role conflict* but can also include reduced personal accomplishment, reduced job performance and depersonalisation (Ortquist & Wincent, 2006). Differences in the ability to tolerate uncertainty account for individual differences in the impact of ambiguities. Those with a 'high need for cognition' are more vulnerable to the effects of *role ambiguity* (Kahn *et al.* 1964, p.87).

The above summary portrays professional identity development as a complex process in which internal and external variables interact to allow learning of new role behaviours and integration of new views of the self as a professional. The professional training process therefore results in:

...an autonomous professional being, who constructed her or his own professional identity, but whose professional identity, level of commitment and projected career strongly reflect the structural and situational variables within the training program. (Bucher & Stelling, 1977, p.279)

1.2. Clinical psychology: the historical context

Clinical psychology is a relatively young profession which produced its first practitioners in the 1950s and was formally established in 1960 (Pilgrim & Treacher, 1992)¹. Hans Eysenck headed one of the first clinical psychology training courses at the Maudsley hospital in London. He emphasised the role of clinical psychologists as researchers and diagnosticians, not therapists, describing therapy as 'essentially alien to clinical psychology' (Eysenck, 1949, p.173). He went so far as to suggest that the two are incompatible, a debate which continues to exist within the profession today

¹ Developments in applied psychology accelerated following the two world wars due to increasing demand for methods to assist in the recruitment and selection of soldiers, the assessment of malingering and the treatment of post-traumatic stress in soldiers returning from war.

regarding the applicability of the scientist-practitioner model to the field of clinical psychology (Pilgrim & Treacher, 1992). This was not a view shared by all, however, as the Tavistock clinic (another of the early clinical psychology training courses) followed a psychoanalytic tradition emphasising a therapeutic approach.

Three *social movements* can be observed in the profession's development: psychometrics, behaviour therapy and eclecticism. Clinical psychology was initially concerned with psychometric assessment, driven mainly by Eysenck and his Maudsley graduates, and was heavily influenced by positivism. In the late 1950s this was replaced by behaviour therapy, driven by Eysenck, Shapiro and Gwynne-Jones. Behaviour therapy evolved as clinical psychologists strove to establish themselves as independent professionals: to move away from the dominance of the medical model and psychiatry, where the power typically resided. The application of behaviour and learning theory to treatment enabled clinical psychologists to maintain the dual role of scientists and practitioners (Cheshire & Pilgrim, 2004). The third phase in the profession's development is that of eclecticism. This reflects the wide variety of theoretical models and treatments (often incorporating combinations of theoretically disparate models such as behaviour therapy and cognitive therapy evolving into the widely used cognitive behaviour therapy (CBT)) that has developed in the treatment of psychological problems and which has occurred because 'clinical psychology failed to develop a firm consensus about its core role' (Cheshire & Pilgrim, 2004, p.14).

The role of the clinical psychologist has changed dramatically in the last fifty years. There is greater involvement in psychotherapy and the care of complex clients than in psychometric assessment and academic research. Two reviews by the Department of Health into the role of clinical psychologists in the health service have been influential in shaping the profession's development. The Trethowan Report (1977) advocated greater autonomy for the profession, recommending that services should be managed independently by health authorities, within an area department of clinical psychology. This moved clinical psychology out of hospitals, facilitated the separation of psychology from psychiatry and gave psychology services managerial autonomy. These objectives

were difficult to implement within the political context of Thatcher's reforms of the NHS management structure, where power was displaced from clinical professions to the hands of managers. However, the commissioning of a review in 1989 by the Manpower Advisory Group of the Department of Health provided clinical psychology with a claim for its unique role and contribution to the NHS through the identification of levels of psychological skills. Level 1 involves building rapport and simple counselling skills; Level 2 involves undertaking very circumscribed interventions that can be manualised; Level 3 involves the ability to develop formulations and interventions according to the specific needs of a particular individual or context. Mowbray (who conducted the review) argued that only clinical psychologists can offer Level 3 skills whilst other health care professionals provide services using Level 1 and 2 skills (Pilgrim & Treacher, 1992). This distinction helped maintain the boundaries between clinical psychology and other health care professions.

A continuing debate regarding the role of clinical psychologists throughout the profession's development is that surrounding the scientist-practitioner model. This model has permeated clinical psychology. However, some authors claim that psychologists struggle to apply its principles to their day-to-day practice (e.g. Kennedy & Llewelyn, 2001).

The fragmented and disorganized nature of the scientific body of psychological knowledge prevents the easy application to practice. The concept of scientist-practitioner is difficult for many to apply because science and practice are fundamentally different in their goals. Science is objective and seeks description. In contrast, practice is primarily aimed at promoting change. Professional psychologists can perhaps more accurately be described as 'scientific practitioners' who are 'trained in scientific methodology and anchor their knowledge base to a basic scientific discipline', which informs their practice (Henriques & Sternberg, 2004, p.1060).

Monte Shapiro conceptualised clinical psychology as an applied science. His son David Shapiro describes the role of the 'applied scientist' (or practitioner) as being:

... to use validated methods of assessment or treatment where these existed. Where they did not, the clinician was to apply scientific principles of observation, hypothesis generation and hypothesis testing to the individual patient. (Shapiro, 2002, p.232)

He argues that the scientist-practitioner model is most relevant when evidence is 'equivocal or lacking' (Shapiro, 2002, p.233). In order to renew the scientist-practitioner model, science and practice need to be better integrated emphasising clinically realistic research. At present the scientist-practitioner model 'primarily reflects an attitude to practice rather than a commitment to participation in the academic community requiring the submission of research papers to refereed journals' (Kennedy & Llewelyn, 2001, p.77). This is most likely a reflection of the gap between the academic and practical fields of clinical psychology. The lack of research activity amongst clinical psychologists is in part a consequence of lack of time and resources afforded to research activity in the context of more immediate priorities such as patient care and management tasks which take precedence over the more abstract task of research (Kennedy & Llewelyn, 2001; Thomas *et al.* 2002).

A tiered approach to the scientist-practitioner model has been suggested for providing a more realistic framework encompassing the broad principles of the scientist-practitioner model to more accurately reflect the realities of clinicians' day-to-day practice:

The empirical clinician who uses validated procedures as a consumer and utiliser of research; the evaluative clinical scientist who utilises the results of R & D to undertake soft pragmatic and implementation research; and the rare clinical scientist who conducts exploratory research. (Milne & Paxton, 1998, p.227)

The scientist-practitioner model has been central to the profession since its inception and it remains prominent in debates within the profession today. There is a current shift in clinical psychology from the scientist-practitioner model to one of evidence-based practice (Cheshire & Pilgrim, 2004). This provides an opportunity to address some of

the barriers to implementing the scientist-practitioner model, by focusing on outcome measures and effectiveness studies (Milne & Paxton, 1998). This follows directives from the Department of Health (1998), through the implementation of clinical governance, for health professions to be more accountable and to demonstrate efficiency and effectiveness in the delivery of health care interventions. In order to achieve this, it appears that the profession would benefit from better integration of academic and clinical branches, and greater time and resources allocated to research activity.

1.3. Current drivers for the profession: the political context

Many of the developments that have occurred in the profession have arisen in response to the political climate of the time, and have been driven by a perceived need for psychology to define and differentiate itself from other professions in order to establish a unique role and to protect its identity.

The current political context emphasises a shift in the balance of health care from a disease model of episodic inpatient treatment to a more proactive and preventive approach, encouraging continuous and targeted care in the community (Delivering for Health, 2005). This has facilitated the development of psychology services within primary care and has provided clinical psychology with the potential for differentiating further from psychiatry and acquiring greater resources for the development of services to meet the needs of local communities (Cheshire & Pilgrim, 2004).

A number of recent government targets and priorities mean that there is increasing demand for psychological interventions. Delivering for Mental Health (2006) outlines a number of Health Efficiency Access and Treatment (HEAT) targets and commitments to enable their implementation. These include reducing the increase in anti-depressant prescribing, reducing suicide rates and reducing hospital readmissions and waiting times. In order to achieve these targets, there is a need for collaborative working between professionals to promote the early assessment and treatment of mental health

difficulties, the development of integrated care pathways and increased access to psychological therapies.

Many departments are working towards these commitments with few additional resources. In addition to the provision of one-to-one therapy for clients with more complex difficulties, this requires clinical psychologists to embrace a number of new ways of working including service redesign and an increase in teaching, training, consultation and the supervision of others in the delivery of psychological interventions. This requires psychologists to draw on a broad range of skills rather than relying solely on their therapeutic skills (Lavender & Hope, 2007).

These drivers have also prompted changes in the training of clinical psychologists, and the creation of new roles in relation to the delivery of psychological interventions to meet the increasing demand for them. These are considered below.

1.4. The training context

Clinical psychology aims to reduce psychological distress and to enhance and promote psychological wellbeing by the systematic application of knowledge derived from psychological theory and data...The core skills of a clinical psychologist are assessment; formulation; intervention; evaluation'. (The Division of Clinical Psychology, 2001, p.2)

Training to become a clinical psychologist requires attainment of an undergraduate degree in psychology (usually at the level of a 2:1 or a first) which awards graduate basis for registration (GBR) with the British Psychological Society. Graduates then need to gain relevant experience working as an assistant psychologist or research assistant prior to applying for postgraduate training. Competition for places is high (in 2007 there were 2,346 applicants for 583 places) and applicants often spend several years working as an assistant before successfully obtaining a training place. Postgraduate training involves three years full-time, or the part-time equivalent,

culminating in a doctorate in clinical psychology. Training incorporates a mixture of academic work, research and supervised practical experience in the workplace, the latter comprising at least half of the total training time. Trainees are expected to gain experience working with a range of different client groups across the life-span (Clearing House for Postgraduate Courses in Clinical Psychology, 2008).

In response to the current political context (section 1.3) more flexibility in clinical psychology training pathways is needed in order to meet increasing demand for services and to incorporate a wider skill mix into the workforce. This will involve redefining the career structure of clinical psychology and its training programmes. Attention has been brought to the huge number of graduate psychologists who possess high levels of relevant knowledge and who provide a readily available workforce. Grades of associate psychologist have been considered in order to provide different career options for graduates of psychology and a more modular approach to gaining doctoral qualifications (Cheshire & Pilgrim, 2004).

In Scotland, training courses for Clinical Associates in Applied Psychology have recently been developed by Stirling, Dundee, and Edinburgh Universities in collaboration with NHS Education Scotland (NES). There are currently two MSc courses of 1-year. These are: an MSc in Psychological Therapies in Primary Care, and an MSc in Applied Psychology for Children and Young People. These courses have the express aim of training people to deliver psychological interventions and providing a swift response to the increasing demand for such roles.

Changes have also been made in Scotland to the University of Edinburgh / NHS Scotland doctoral training programme with the introduction of flexible training: an alternative route to chartered status. This was developed by the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE, now incorporated within NES) in response to the increasing demand for clinical psychologists and the difficulty that training courses have in meeting this demand. In 2003, a Workforce Planning for Psychology Services in Scotland report by NES stated that:

Even with 64 trainees in each of the 3-year training programmes, it would take 38 years to double the current stock of trained clinical psychologists in the work force. (NES, 2003, p.7)

Flexible training is spread over four or five years. It consists of the same core training components as the 3-year course and the first year is identical in both models. The remaining three or four years of the flexible model is split equally between completing the training components and providing a service contribution to a designated clinical specialty and area of service need. This means that flexible trainees can begin to provide a valuable service contribution after their first year of training in a particular specialty, and employers can respond to increasing demand in specific areas of clinical need.

1.5. The research context

1.5.1. Previous research on professional identity development in clinical psychology trainees

Research into professional identity development in clinical psychology trainees is scarce. Most studies involving clinical psychology trainees focus on their psychological adaptation and the factors affecting their response to the challenges of clinical training (Brooks *et al.* 2002; Kuyken *et al.* 2003)². The most comprehensive study to date is a longitudinal and cross-sectional study of the professional socialisation of clinical psychology trainees on the University of Edinburgh/East of Scotland Clinical Psychology Training Course conducted by Cheshire (2000b). This study examined anticipatory socialisation and the transition into the workforce upon qualification by

² Several personal accounts of the training experience have also been published in Clinical Psychology Forum, the Division of Clinical Psychology professional newsletter (Baker, 2002; Gorsuch, 1994) highlighting some of the difficulties trainees face in developing a professional identity and negotiating clinical training.

sampling assistant psychologists and newly qualified clinical psychologists as well as trainees in all three years of training.

Cheshire's (2000b) exploration of trainees' passage through training revealed stages in the mastery of clinical skills and in level of confidence. This ranged through feeling like 'pretend psychologists' in 1st year due to uncertainty and anxiety about what to do with clients and a sense of frustration that the course did not hold all the answers; a greater belief in themselves as 'real psychologists' during 2nd year as their confidence increased; to a more flexible application of theory to practice, and greater tolerance of ambiguity and complexity in their work with clients during 3rd year when they described increasing self-confidence and a consolidation of their learning.

Cheshire (2000b) identified a number of role conflicts and ambiguities that interfere with the development of mastery. Trainees experienced role conflict with respect to their dual role as a student and an employee. They described the demands of the university and their clinical work as being incompatible at times, particularly during 3rd year when completing their thesis. Professional-bureaucratic conflict arose when a lack of choice regarding placements was considered to impact on the quality of training. They felt disempowered within the overall course structure, feeling unable to effect any changes in their training due to bureaucratic or organisational constraints. Person-role conflict was described when their own values conflicted with those of the profession or of the course, for example in the rigid application of CBT as the dominant model of treatment. They also experienced role ambiguity as a result of 'insufficient or misleading feedback from supervisors' (Cheshire, 2000b, p.155) in terms of both their clinical and academic work.

The transition from trainee to qualified practitioner was characterised by a considerable amount of stress. Despite the benefits of increased responsibility, increased autonomy and better pay, many trainees experienced feelings of demoralisation, as a result of

feeling deskilled and overwhelmed by the demands of their new jobs. The stressors reported were:

...increased workload, the greater complexity of the cases, lack of experience in dealing with termination issues in therapy, lack of experience in case management, the increase in clinical responsibility and the strain of being perceived as an expert while considering oneself to be inexperienced. Most of the class reported that they habitually felt drained and tired during their first post-qualification year and acknowledged that they had not been prepared for the emotional impact of full-time clinical work. ' (Cheshire, 2002, p.31)

They also reported difficulty maintaining boundaries around their clinical work, often taking on more than was realistic, which left less time to read and prepare for sessions. Having to extend their knowledge in two different areas, including some which were new to them, or which they had not worked in since the beginning of their training, was an additional stressor associated with the demands of a split post. They also felt increasingly isolated due to a loss of contact with their peers and limited contact with other psychologists. The factors assisting them during the transition were regular supportive supervision, assistance to pace work, informal supervision arrangements and peer supervision. Mastery experiences in other domains also helped foster a sense of competence, for example, supervising assistants or other professionals, service development or consultancy work (Cheshire, 2002).

1.5.2. Personal reflections and the pilot study

My initial interest in this area arose out of reflections on my own experience as a flexible trainee. My experience of 2nd year felt very different from that of 1st year. When I began my work component, I felt under more stress and more isolated from my peers as a result of having to juggle a split post, cope with a reduction in study time and attend teaching with different year groups. I was aware of similar feelings of stress, frustration and a lack of confidence amongst other flexible trainees in comparison to

3-year trainees in my cohort. This contrasted with Cheshire's (2000b) finding of increased confidence in ability amongst 2nd year trainees. I was curious to explore these perceived differences further. A small-scale research project, comparing the training experience of both flexible and 3-year trainees, formed the pilot study for this thesis project. A thematic analysis of four focus groups (two with 3-year trainees and two with flexible trainees) was conducted to explore these issues in more detail.

Two major differences between the experiences of flexible and 3-year trainees emerged from the pilot data: the impact of both the peer group split and the work component on the training experience. During 2nd year, flexible trainees described feelings of isolation as a result of the split from their year group for teaching, and increased feelings of stress due to fewer opportunities to share their experiences with their peers and thus engage in their greatest source of support. The impending graduation of their 3-year peers before them affected their ability to develop a sense of group identity as a cohort, although they described a stronger sense of identification with their flexible trainee peers.

Identity development was compounded for flexible trainees by their triple role. All trainees found it difficult to manage the tension between their role as a student and that as an employee. However, this was compounded for flexible trainees by the added tension between their role as a trainee on placement and their role during their work component. Lack of clarity regarding what was expected of trainees in this role led to feelings of being undervalued or 'exploited' by line managers, who were also unsure of the flexible trainee role. This was reflected in the wide ranging experiences described by trainees in their work components, some being treated like assistants and others being treated like qualified members of staff. Other aspects of flexible training, such as the split post and lack of elective placement choice, added to their stress and time pressures, which they felt affected the quality of their training. Flexible trainees also described experiencing lower status within the organisation in comparison with 3-year trainees. This reduced their feelings of confidence and led to apathy and a sense of helplessness about effecting any change in their situation. Uncertainty as to how their qualifications

would be viewed, fuelled by staff's apparent lack of understanding of the flexible training model, was also of great concern and had a negative effect on their sense of self-worth. I was interested to explore the development of these themes as flexible trainees progressed through their training and after their 3-year peers had graduated.

The experience described by flexible trainees at the start of 2nd year, when beginning their work component, seemed to mirror the difficulties identified during the transition from trainee to qualified practitioner in 3-year trainees (Cheshire, 2002; Clare & Porter, 2000). Flexible trainees described feeling 'flat, tired, stressed and unmotivated' characteristic of the feelings of demoralisation found amongst newly qualified staff in Cheshire's (2002) work described above. The stress of embarking on their split posts, which were often in two new areas of work, was compounded by lack of clear expectations within the flexible trainee role, a reduction of study time and increasing isolation from their peers. I was therefore interested to explore flexible trainees' transition to qualified practitioner in comparison with their 3-year peers, given their earlier transition and different training experiences.

1.5.3. Research aims and questions

The pilot study raised interesting questions about the continuing impact of the unique aspects of flexible training (namely the work component and the different training structure) on professional identity development. This study aims to explore the differences between 3-year and flexible trainees, regarding the development of mastery of the clinical psychologist role and trainees' view of themselves during the latter stages of their training and in the transition to qualified practice. It focuses on flexible trainees' 4th and 5th years of training and the first post-qualification year for 4-year flexible and 3-year trainees. Given the time scale, it is only possible to conduct a preliminary investigation of the transition into work for flexible trainees as the first cohort graduated

in 2007. However, I hope to gain some insights from this preliminary data. The research questions are as follows:

- 1) How does the work contribution in their designated clinical specialty affect the mastery of clinical skills and self-confidence of flexible trainees in comparison to 3-year trainees?
- 2) How does the work contribution in their designated clinical specialty affect flexible trainees' views of themselves as clinical psychologists in comparison to 3-year trainees?
- 3) How might the experience of flexible training affect the transition from trainee to qualified practitioner?
- 4) Do flexible and 3-year trainees experience the same degree of role conflict and ambiguity? What factors influence this?

1.6. Personal reflections on professional identity and the research process: the personal context

Given my own experiences of being a flexible trainee as described above, I had a number of expectations prior to the research and made the following predictions:

- Flexible trainees would place greater importance on their work component than their placements (if this is the area in which they wish to work).
- Flexible trainees would begin to feel more competent in their work component due to their continuous experience in this area. This is likely to be linked with the degree of responsibility and autonomy they were afforded in their work component.
- 4th year flexible trainees would experience conflict between their identity in their work and their identity as a trainee on placement. The lack of title may be crucial to this.

- Flexible trainees would struggle to see how they are perceived within the department and where they fit in their work component.
- The conflict between the trainee and work component roles would lead to a lack of self-confidence, and feelings of lack of value and recognition of their abilities.
- Flexible trainees would feel more competent than their peers during the transition to work.
- Newly qualified 3-year practitioners would enjoy a number of roles and responsibilities involving a greater degree of autonomy and authority.
- Newly qualified 3-year practitioners would experience some anxiety in relation to the challenges of their new role, such as building up and consolidating their knowledge base, managing split posts, managing long-term cases, termination issues and some trainees may feel deskilled or lacking in confidence as they adjust to their new role.
- Those who were supported, included and valued within the departments in which they worked would be better able to manage these challenges. Those who lacked support or did not feel included in the department would feel less confident.

In my reflective diary I have documented my own sense of developing professional identity prior to data collection and throughout the research process. I will summarise the main points documented prior to data collection on 13/02/07 during my 4th year of training in order to orient the reader to my beliefs, assumptions and expectations prior to the research. In chapter 4, I will comment on how the results compare to my own experiences and predictions and on how the research process has changed my views on professional identity development in clinical psychology trainees.

In 4th year my thoughts were dominated by looking forward to finishing, to the point where I would have a 'proper' title and not be a trainee. I felt that I would be well prepared for work given the breadth and depth of my experience. I had many opportunities both to develop existing skills and acquire new ones in my work component, and a great deal of input to shaping my own development. I felt confident

in my work, having opportunities to manage my own case load, deal with complex cases, deal with termination issues and develop skills in a wider range of treatment methods. I felt well supported by my line manager who had a good understanding of flexible training and who gave me appropriate support and autonomy. I also felt like a valued member of the team who was included in the department which helped to boost my confidence.

In contrast my core placement (in an area, in which I knew that I did not want to work) felt like a tick-box exercise, less tailored to my individual development needs. I noticed increased pressure on my time as a result of a number of competing demands including a new placement, a number of academic assignments to complete, embarking on my thesis and participating in a number of projects within my work component to enhance my development portfolio. I wanted to prioritise my work because it was of greater interest to me and I felt that it was more relevant to my personal and professional development goals. I was constrained in the amount of time that I was able to invest, which was frustrating and created conflict between my work and my placement.

Increasingly, I felt conflict in my role as a flexible trainee. In my work component I was considered to be equivalent to a qualified member of staff and in my placement I was considered to be a trainee. Having the title of Trainee Clinical Psychologist for both parts of the job did not differentiate between the two roles, acknowledge my stage of training or differentiate me from 3-year trainees. This had obvious implications for my professional identity. I thought of myself as a clinical psychologist during my 4th year of training because I was confident in my abilities and skills to perform this role and felt as competent as a number of 3-year newly qualified clinical psychologists in the department. The trainee title undermined these feelings of competence. At times I felt that flexible trainees were not acknowledged. For example, I experienced feelings of lower status on placement when being evaluated at a stage when many of my peers were not (having qualified after 3 years). I became selective about the roles that I took on in my placement, participating in those that I felt would be helpful to my development and

refusing those that I did not. It felt strange being excluded from certain things on placement because I was a trainee (something that my 3-year colleagues would now not have to endure). This made me invest less in my placement and focus more on my work, where I was included and where I felt that my contribution was valued. I felt frustrated and demoralised at these times and progressively less enthusiastic about my training and the course, and more enthusiastic about finishing the course and starting work. This was highlighted and exacerbated by the graduation before me of my peers who were then able to enjoy professional and personal freedom and autonomy. This was difficult given the lack of a clear role for flexible trainees and the lack of formal acknowledgement of our experience and training.

The academic teaching blocks with different year groups were difficult to negotiate in 4th year. I felt that they did not accommodate trainees in different years. There was no developmental aspect to the teaching and little continuity. It felt less relevant to my development and it was at times very isolating (being the only person in my cohort doing a particular teaching block). The lack of freedom of choice and ability to take control over my own learning contrasted to the treatment I received in my work component where I enjoyed a lot of autonomy and responsibility for my own learning and development.

All of these experiences contributed to feelings of uncertainty about my professional identity in spite of a sense of competence in the role of clinical psychologist. At times I identified strongly with this role but at other times my trainee status prevented me from doing so. I felt very lucky having the opportunities I did in my work component and was aware that many of my peers had quite different experiences. I was therefore interested to explore the impact of their differing experiences on their professional identity development.

My reflections raised a number of questions important in developing a comprehensive understanding of the factors affecting professional identity development while exploring

the similarities and differences between my experience and that of my flexible and 3-year peers:

- Will flexible trainees invest more in their placements if they do not like their area of work?
- How does this affect their feelings of confidence and competence?
- What is the impact on flexible trainees' identity and feelings of competence if they are not afforded opportunities for development or appropriate autonomy in their work components?
- What factors influence the conflict between their work and placement identities?
- How are flexible trainees perceived by others and what impact does this have?
- How do they manage the transition to work and how do they see themselves in this role?
- What was the impact of the graduation of their peers before them?
- What do newly qualified 3-year practitioners expect from their first year of work post-qualification?
- What were they looking forward to in their work and what did they consider would be the main challenges?
- What was their graduation experience? How did it feel to be graduating ahead of half of their class with whom they started their training?
- What is their experience of working alongside their flexible trainee peers as a qualified clinical psychologist?

Summary

In this chapter I have provided a context for this thesis research. This includes the theoretical background to professional identity development and the historical, political and training contexts of clinical psychology. I have also presented my personal rationale for developing this research project and presented my reflections on my own

professional identity development and my predictions prior to conducting the research. This is particularly important given my role as a flexible trainee in order that my own experience and assumptions are made explicit so that they can be differentiated from the experiences of others and the reader is oriented to them when interpreting this research.

2. METHODOLOGY

In this chapter I will present the rationale for adopting a qualitative approach in this study. The first part discusses some common characteristics of qualitative approaches, followed by an account of the specific qualitative methods chosen for data collection and analysis. The second part describes the procedures of recruitment, data collection, management and analysis in detail. In the third part I address issues of ethics, reliability and validity.

2.1. Design

2.1.1. Qualitative research methodologies

This study is a naturalistic, exploratory study of the experiences of the current generation of clinical psychology trainees with particular focus on the impact of the flexible training scheme on the process of professional identity development. The aim is to identify factors which both nurture and impede the development of professional identity within the different training models.

A qualitative design is best suited to these research aims. Qualitative research is a broad term encompassing a wide range of research methodologies which have been influenced by a number of different philosophical traditions (Patton, 1990). However, they share a number of common characteristics which are better suited to certain topics of enquiry and which are discussed below with reference to the current study.

Qualitative designs are naturalistic. They seek to understand phenomena as they occur naturally in the world, without variable manipulation or predictions regarding research outcomes. This contrasts greatly with quantitative, experimental designs where

hypotheses are constructed and variables are manipulated and controlled to test these predictions. This control and manipulation of the research setting creates a context that is artificially constructed and therefore removed from everyday social reality (Patton, 1990). A naturalistic study of professional identity development therefore enhances the ecological validity of the findings. Adopting a qualitative design also places this research within the body of existing literature on professional identity development which predominantly utilises qualitative methodologies, due to the nature and complexity of the topic.

Qualitative methodologies enable the complexities of individual experience to be studied. The primary aim is to uncover subjective meanings grounded in data that reflect diversity within the topic under investigation. Variety of experience is embraced and exceptional cases are sought out to elaborate theory and deepen understanding of a particular phenomenon (Flick, 2002). In contrast, quantitative methods seek to produce generalisations: aggregating the diverse experiences of individuals in the search for generalisations serves to decontextualise these experiences and their meanings, creating general rules which are unable to reflect the complexities and intricacies of a particular social reality. Qualitative designs are therefore better suited when the primary goal of the research is to develop a deeper understanding of individual meanings and experience, and where it is important to explore the phenomenon in its natural form.

Fieldwork is an essential component in this endeavour. It requires the researcher to get close to the participants; to engage with them and their reality in order to gain insight into their experiences and the meanings they apply to these experiences. This contrasts with the ‘detachment’ from participants, characteristic of quantitative methodologies, which is seen as an essential safeguard for reducing bias and preserving objectivity:

...qualitative evaluators question the necessity and utility of distance and detachment, assuming that without empathy and sympathetic introspection derived from personal encounters the observer cannot fully understand human behaviour. (Patton, 1990, p.47)

The qualitative researcher is sceptical or rejecting of objectivity as a concept: ‘...the notion that a scientist can stand outside his or her own personal frame of reference to view objects or events in a neutral way’ (Stiles, 1993, p.602). Any activity the researcher is involved in is influenced by their prior knowledge, experiences and beliefs, thus ‘detachment’ from participants is arguably neither useful nor necessary in the study of human behaviour. Rather, Stiles (1993) describes the notion of *permeability* within qualitative research as ‘...the capacity of theories or interpretations or understandings to be changed by encounters with observations’ (p.602). Thus one of the qualities and perceived strengths of qualitative research is the ability of close interaction with participants, settings and data to change the researcher’s understanding or interpretation of the phenomenon under study.

Qualitative research is therefore a dynamic and circular process in which the researcher is an integral part:

The field researcher is directly and personally engaged in an interpretive focus on the human field of activity with the goal of generating holistic and realistic descriptions and / or explanations. (Miller & Crabtree, 1992, p.5)

The researcher is required to reflect on the data and the processes of data collection and analysis throughout. Their subjectivities are acknowledged as an inherent part of the process of knowledge production and their contribution to the development of a theory is explicitly stated. The researcher’s reflections are considered a source of data in their own right, and are integrated into the interpretation, rather than excluded as is the case in quantitative approaches (Flick, 2002; Janesick, 1998). This enables the reader to assess the *permeability* of the researcher’s interpretations; that is, the extent to which their interactions with participants and the data has altered their understanding of the research topic. These concepts are further discussed in section 2.3 with reference to reliability and validity in qualitative research.

The iterative nature of qualitative research means that data collection and analysis are interwoven, each informing the other. As a result, designs are often flexible: research aims guide the initial sampling, data collection and method of analysis. This, however, might change and evolve as new understandings are developed, and shape the ultimate research design (Patton, 1990).

A number of characteristics common to qualitative research designs indicated that this is the most appropriate methodology to meet the aims of this study. It is important that the methodology allows detailed description of the subjective meanings of individual experience which both accurately reflect the social reality under investigation and allow diversity of experience to be reflected. Due to the exploratory nature of this study, a flexible design is required to enable the selection of participants and methods of data collection so that specific focuses of enquiry can be pursued following the initial analysis, to enhance the researcher's understanding.

2.1.2. Constructivist grounded theory

A constructivist grounded theory approach was considered most appropriate in meeting these aims. Grounded theory was first developed by Glaser and Strauss in 1967, in response to their view that the dominant approach in sociological research was one of theory verification rather than theory generation. They define grounded theory as 'the discovery of theory from data' (p.1) which contrasts with deductive methods that seek to test hypotheses developed from *a priori* assumptions³. Grounded theory starts from the position of suspended knowledge. It is exploratory and inductive in nature. Hypotheses are developed from the data and continually evaluated, and revised through the process of constant comparative analysis to develop a theory grounded in the data from which it is derived (Glaser & Strauss, 1967).

³ The beginnings of grounded theory have been described as "polemic" (Dey, 1999) because they challenged deductive methods of theorizing where the role of research is one of verification, and offered grounded theory as an alternative method where the role of research is one of theory generation.

Charmaz's (2003) constructivist version of grounded theory emphasises documentation of the research process and reflexivity throughout. It acknowledges the role of the researcher in the construction of data and in their interpretation of it through their interaction with participants and data during collection and analysis.

I felt that a constructivist grounded theory approach was most appropriate for a number of reasons. It would facilitate an in-depth understanding of the individual meanings applied to the training experience and their effect on the development of professional identity. It would also facilitate the derivation of conceptual categories from the raw data to ensure that the emerging hypotheses accurately reflect the current political, social and organisational climate of the training experience. Grounded theory is useful when 'the researcher wants to stay close to the data and perform a detailed analysis of the text' and when 'the researcher wants to use a method of analysis that keeps their own interpretive activity at bay until later stages of the analysis' (Dallos & Vetere, 2005, p.54). Due to my role as a trainee and my relation to the participants, this methodology offered several advantages. It would enable me to stick closely to the data: analytic methods including line-by-line coding and constant comparative analysis, characteristic of this approach, would enable me to bring my interpretations of the data in at a later stage of the analytic process, once descriptive and conceptual categories had been derived from the texts. Constructivist grounded theory's emphasis on reflexivity and the role of the researcher in both the construction and analysis of data would also be important. This method would therefore enable me to reduce the impact of my own biases and preconceptions on the emerging theory through explicit documentation of my reflections on these processes, and their relation to the data and my interpretation of it. This then allows the reader to evaluate the impact of my biases and preconceptions on the data collection and interpretation of results.

2.2. Procedure

2.2.1. Participants

Participants were all current or past trainees on the University of Edinburgh / NHS Scotland Clinical Psychology Training Programme. Sampling was based on theoretical relevance (Yardley, 2000). I was particularly interested in exploring the experience of flexible trainees in their 4th and 5th years and in the transition to work. As the 2003 cohort is the first cohort to include flexible trainees this was the only suitable group from which to obtain such data, therefore all participants were members of this cohort. Individuals were invited to participate by e-mail, detailing background information about the study and what their participation would involve (appendix 1). Participants were recruited in their 2nd, 4th and 5th years. Those who qualified after three or four years were invited to participate between six and nine months post-qualification. Data collection occurred at three different time points (see table 1 below). The pilot study (conducted in 2005, the cohort's 2nd year of training) indicated that further investigation of the experiences of flexible trainees in their 4th and 5th year and a comparison of the experience of 3-year and flexible trainees in the transition into work would be of interest. Therefore, two further data collection periods were conducted in 2007 and 2008 in the cohorts' 4th and 5th years. Data collection took place between the months of February and May, approximately six to nine months into the academic year. This was to ensure that participants had experienced a significant part of the relevant year of training or post-qualification work to be able to comment on it. The exact data collection point was influenced by the practicalities of arranging suitable times for focus groups (which were arranged during cohort teaching days, when all participants would be in the same location) and individual interviews. The above is summarised in table 1 below.

In total 17 of 19 flexible trainees (89 per cent of the cohort) and 12 of 20 3-year trainees (60 per cent of the cohort) participated in the research.

Table 1: Data collection timetable

Pilot study T1: 2nd year	Data Collection 1 T2: 4th year	Data Collection 2 T3: 5th year
3yr (n=9)	4 and 5yr flexi (n=14)	5yr Flexi (n=7)
Flexi (n=12)	3yr 6mths PQ (n= 6)	4yr Flexi 6mths PQ (n=4)
KEY		
3yr = 3-year trainees	T1 = 1 st data collection point: May / June 2005	
Flexi = Flexible trainees	T2 = 2 nd data collection point: February–June 2007	
PQ = Post-qualification	T3 = 3 rd data collection point: February–April 2008	

2.2.2. Data collection

A combination of focus groups, individual interviews and written reflections about specific events were used to collect the data, as is illustrated in the table below:

Table 2: Data collection methods

Time Point: Year of Training	T1: 2nd year (pilot)	T2: 4th year	T3: 5th year
Number of Focus groups	2 3yr 2 Flexi	2 3yr PQ 2 Flexi	2 5yr Flexi
Number of Individual Interviews	N/A	2 Flexi 1 3yr PQ	4 4yr Flexi PQ
Written reflections on Graduation Day	N/A	N/A	1 3-year PQ 4 4yr Flexi PQ 4 5yr flexi

Focus group discussions were open and relatively unstructured to allow the emergence of themes from the groups. This format greatly facilitated discussion amongst group members and researcher input was minimised to keeping the discussions on topic. Less structured formats are advocated for exploratory research and when it is desirable to minimise the researcher's involvement in the discussion (Morgan, 1997). There are a number of advantages and disadvantages to my being a member of this cohort of

trainees, which I have considered elsewhere (see section 2.3.2.1.-2.3.2.2). With regards to data collection, however, I think that being part of the naturally occurring group (i.e. a member of this cohort of trainees) had several advantages. It is in this social network that participants would be most likely to discuss the issues raised in the focus groups. Familiarity with each other and with me meant that the discussions flowed freely and participants appeared to feel comfortable discussing issues about their individual and shared experiences, perhaps more so than they would have with someone they did not know or who knew less about the current training system (Kitzinger & Barbour, 1999). Focus groups can also broaden the range of views and experiences included in the research by increasing participation of members who might be reluctant to participate in an individual interview. A potential disadvantage of my being a trainee is that I could have led the discussion in a particular direction based on my own views and assumptions. However, the focus group methodology encourages discussion amongst group members and ‘shift [sic] the balance of power in favour of the participants’ (Kitzinger & Barbour, 1999, p.18). I was conscious of this and minimised my participation.

The groups ranged in size from two to six participants (the group of two had originally comprised three members but one was unable to attend on the day). Small groups were considered appropriate in this study because the participants knew each other well and the topic was of great interest and personal relevance to them (Morgan, 1997). To maximise convenience, the focus groups were conducted at the University Clinical Psychology Department or at participants’ work places. Some individual interviews were conducted in participant’s homes.

Separate focus groups for flexible and 3-year trainees were considered likely to be most productive. Greater homogeneity would encourage more free-flowing discussions and would facilitate comparison between the two groups (Kitzinger & Barbour, 1999; Morgan, 1997). All those who opted in to the study were included and the composition of the groups was based on convenience for participants.

The focus groups were augmented by individual interviews and written accounts to gain a more in-depth understanding of the process of professional identity development and to identify factors that participants may have been unwilling to discuss within the group. Individual interviews were used in theoretical sampling to further explore aspects of the developing hypotheses, and to seek out individuals whose experiences were less prominent in the group or were different to the dominant themes expressed in the groups (Michell, 1999).

All of the data collected with the 4-year flexible trainees post-qualification was in individual interview format. Practically, it was impossible to get all of the participants together to run a focus group. However, due to the small number of participants within this group who opted in (4) and their importance with regards to the developing theory, individual interviews were more appropriate in order to explore their experiences in greater depth.

I also invited participants to write about their reflections on the graduation in 2007 of the 4-year flexible trainees and 3-year trainees in the cohort below. The graduation of the 3-year trainees in 2006 was a much discussed event in all of the focus groups and individual interviews. Initial analysis of this event highlighted its variable impact on different individuals and I wished to explore this further. The questionnaire can be seen in Appendix 2.

2.2.3. Data management

The focus groups and individual interviews were all digitally recorded and transcribed (in the main by myself) in order to facilitate immersion in the data. All recordings were destroyed following transcription and the transcripts were stored securely. Care was taken to anonymise participants and to remove any potentially identifying information

from the transcripts. Where possible, a replacement descriptive for any identifying information was inserted in brackets to orient the reader. Due to the low proportion of male trainees in the sample and the potential for their identification, all participants are referred to as female, as are people mentioned in the texts, including supervisors and managers.

2.2.4. Data analysis

The computer package NVivo 2 (QSR, 2002) was used to help organise and manage the data and its analysis.

All of the transcripts were initially openly coded line-by-line (Charmaz, 2003). Early coding was descriptive (see appendix 3 for an example of transcript coding). As coding progressed, analytical categories were developed, grouping together similar descriptive codes into meaningful units for further exploration. This process is facilitated by the identification of action codes, as these enable comparisons between participants, events, and categories. They help the researcher to identify processes that link categories together which is central to theory development (Charmaz, 2003). Identification of the similarities and differences between and within categories enables the researcher to develop and refine categories and to identify sub-categories. For example, an early theme emerging from the data was the conflict experienced by participants between their ability and status in their role. This occurred in different situations (e.g. during 3-year trainees' transition into work and flexible trainees' 4th year of training). Appendix 4 provides a summary of the different levels of coding within this broad category. Comparisons of the similarities and differences amongst these codes and between the two groups highlighted core themes relating to this conflict: competence, status, comparisons with others and expectations of others. Further analysis of these core themes across other categories led to the refinement and development of the final categories presented in chapter 3. This constant comparison of categories and the data

represented within them facilitates the development of a theory that integrates the diversity and variation that exists within the data (Willig, 2001). Memo writing is a useful process for identifying questions to be asked of the data as the researcher's understanding and interpretation of it develops. Memos were used to record ideas about the data, about refining the emerging categories and about the emerging relations between categories.

Throughout this process, data collection and analysis were carried out congruently. Initial focus group transcripts were coded and analysed and emerging themes were discussed in the following focus groups and individual interviews. For example, participants discussed a number of conflicts in the initial focus groups between their ability and status, and their work and training components. Appendix 5 shows the focus group guide used to further explore these topics in subsequent interviews. Negative cases were sought to test out emerging theories as they arose. Prior to the final round of data collection, the emerging theory and themes were presented to the participants for further discussion and elaboration.

2.3. Ethics, reliability and validity

2.3.1. Ethical considerations

Due to the potentially sensitive topic of this research I first sought permission from the University of Edinburgh Clinical Psychology Training Course to develop my pilot small-scale research project, by broadening its focus to explore the impact of the flexible training scheme on the development of professional identity. The course granted permission to conduct this research with the proviso that I inform NES of the project to ensure that there was no overlap with an evaluation of flexible training that they are currently conducting. My clinical supervisor, Dr Katherine Cheshire, sits on the NES flexible training evaluation steering group. Having liaised with Dr Ann Smyth (Head of

Psychology services at NES), she considered this to be an adequate safeguard to ensure the two projects did not overlap, or place too much burden on trainees with regards to their participation.

I consulted Mr R. Buchan, the local chair of the NHS Fife Ethics Committee, about obtaining ethical approval for the study. Having seen the research protocol, however, he informed me that the project did not require ethical approval from the committee. The University of Edinburgh were also satisfied with the decision by NHS Fife Ethics Committee and informed me that no further ethical approval was necessary through the University (see appendix 6). Management approval for conducting the research was sought from NHS Fife's Research & Development department, and was granted (see appendix 7).

2.3.2. Reliability and validity

Due to the differing aims, objectives and methods of data collection and analysis of qualitative research compared with those of quantitative research (i.e. to uncover subjective meanings and explanations of individual experiences related to specific and local contexts rather than to seek generalisations), different methods of assessing reliability and validity are warranted. Reliability and validity in qualitative research are concerned with trustworthiness and the credibility of the explanation given in relation to the description of the field of study (Janesick, 1998; Stiles, 1993):

Reliability refers to the trustworthiness of observation or data; validity refers to the trustworthiness of interpretations or conclusions. (Stiles, 1993, p.601)

The following section outlines the methods used to ensure reliability and validity within this research project using Yardley's (2000) criteria for assessing the value of qualitative

research as a framework. The criteria are: sensitivity to context, commitment and rigor, transparency and coherence and impact and importance.

2.3.2.1. Sensitivity to context

Yardley (2000) describes three important contexts which should be considered by the researcher:

1. *The context of existing theory developed from previous research in the topic area:* knowledge and understanding of the relevant theoretical concepts and assumptions in the field can greatly enhance the researcher's interpretation of the data. However, it is crucially important to ground these links to existing theory in the data and to actively seek out findings that differ from the researcher's developing understanding (Yardley, 2000). The theoretical context of this study is described in the introduction (section 1.1) to orient the reader and is discussed in relation to the findings in chapter 4. My interpretations are grounded in the data through the provision of transcript extracts to illustrate the theory or concepts described. To develop my interpretation further, I have sought to identify conflicting experiences or processes amongst participants throughout the analysis. Where a general trend in types of experience has arisen I have actively sought out people whose experience differs from this in order to develop a deeper understanding of the phenomenon. I have also taken my developing theory back to participants to seek both confirmation and disconfirmation of different aspects of it and to explore conflicting issues in more detail.
2. *The socio-cultural context of the study setting:* '... the normative, ideological, historical, linguistic and socio-economic influences on the beliefs, objectives, expectations and talk of all participants (including those of the investigator)' (Yardley, 2000, P.220). Clinical psychology is a relatively young profession

which has seen rapid change over the last fifty years in the role of clinical psychologists (see section 1.2 for a detailed discussion). Factors within the socio-cultural context that are currently influencing the profession are: changes to the NHS pay system (Agenda for Change); the introduction of statutory regulation and an increased drive for rigorous assessment of competence and continued professional development; and an increased demand for access to psychological interventions leading to the development of different roles within psychology and to changes to training programmes. It is important to consider the impact of these contexts on trainees' experiences. This will be further discussed in chapter 4.

3. *The context of the relationship between the researcher and the study participants, in particular the relationship of power between the two*: this is particularly important in this project, given my role as a trainee, and as a friend and colleague of many of the participants. There are potential disadvantages of this position:

a) Participants may have felt obliged to take part.

I did my utmost to make explicit in the participant information that participation was entirely voluntary and was in no way connected to their training. Some people did not take part and this has not affected my relationships with them. However, the majority of the cohort did participate and I believe that this is due to the value they placed on the research topic and the salience it held for them.

b) Participants may have misinterpreted my role and the aims of the research.

Yardley (2000) discusses the balance of power between participants and researcher and some of the difficulties of knowing the participants well. Participation in the research was empowering for many participants. They felt as though their views were being heard and they saw their participation as a means of increasing awareness about their experiences and of effecting change. This is

a powerful motivator and an important aspect of the research project. I intend to publish this research and to disseminate the findings more widely to interested stakeholders, which may serve to increase awareness of the trainees' experience of training and the factors that both hinder and impede professional identity development. At times, however, I felt as though I, and the research, were awarded greater power and influence than was warranted. I felt that participants' expected me to use my 'inside knowledge' to represent them on various committees and working groups or as class representative to the course. On every occasion that I was nominated for such a role, I declined. It would have been impossible for me to differentiate my knowledge of people's experiences and feelings expressed during the research and those which they wished to be communicated at a particular meeting or committee. Furthermore, it would have been inappropriate to disseminate any findings out of context and before analysis was complete. Because of my communicating these conflicts of interest openly and honestly to the participants, they accepted my stance and my reasons for declining.

- c) Participants may have been wary about disclosing personal issues to me and the group given our existing relationship and our continued contact after the research.

I am certain that this could have been a limiting factor, however the discussions appeared to be very open and a wide range of honest and personal views were discussed within the groups. Participants also disclosed thoughts, feelings and experiences that I had not been aware of prior to conducting the research, indicating a degree of comfort within the group and interview settings, and a degree of trust in myself to interpret their experiences accurately.

- d) I might have assumed too much given my 'inside knowledge'.

Sharing many experiences with the participants made it more likely for me to assume an understanding of the thoughts, feelings and experiences they

expressed. I have addressed this difficulty by paying close attention to aspects of the data which have surprised me or which are different to my own expectations and experiences. The process of concurrent data collection and analysis helps to reduce the impact of this, as emerging categories and concepts can be presented in the next round of interviews for further clarification.

On the other hand, my being a trainee has several advantages:

a) Greater access to participants.

My position has helped immensely in terms of access to participants. My knowing many of the participants encouraged their participation, as they trusted me to represent their views fairly and accurately.

b) Redressing the balance of power.

My role as a colleague meant that the balance of power was relatively equal: I was not seen as an expert researcher but as a person genuinely interested in their experiences. I believe that they felt comfortable talking to me as a result of this, perhaps more so than they would have been talking to a stranger (Yardley, 2000).

c) Greater understanding of the current training context.

As I am sharing this experience, I believe that I could bring an understanding to the interviews and focus group discussions that someone with little knowledge of the training course and current systems could not.

Every researcher's position and relationship with participants has trade-offs in terms of advantages and disadvantages. I hope that I have utilised my privileged position well to pursue the aims of the research and have attempted to address any disadvantages arising from my role by being as transparent and reflexive about the research process as possible.

2.3.2.2. Commitment and rigour

This refers to ensuring a comprehensive and thorough approach to data collection and analysis. The methods I have used within a constructivist grounded theory approach have been described in detail above to provide the reader with information about each stage in these processes. In addition to thorough and rigorous methods of data collection and analysis, commitment and rigour also refers to the ‘completeness of the interpretation’ (Yardley, 2000, p.222). This requires that all variation is incorporated into the theory. The methodology itself (constructivist grounded theory) aims to develop theory and thus goes beyond a descriptive account of individual experiences. In order to develop a complete and integrated theory, I have actively sought to explore variation in experience, seeking negative cases to test emerging hypotheses about the relationships between categories. A longitudinal design adds to the completeness of the developing theory, as it enables comparisons between different groups over time which is of central importance in this study. Triangulation of different data sources and methods can also help to provide a more complete interpretation of the data.

Triangulation

Triangulation is a means of validating research findings through the comparison of different data sources, different methods of data collection and the use of different approaches to validating the data analysis. The methods of triangulation used are described below:

Triangulation of methods of data collection

I have used a range of methods of data collection including focus groups, individual interviews and written accounts about particular events. This has enabled me to capitalise on both the advantages of focus groups in facilitating the discussion of issues amongst group members, and the advantages of individual interviews and written accounts for facilitating more detailed personal reflection.

Triangulation of existing literature

Triangulation of the data to existing literature by comparing the similarities and differences between the research findings and the current research in the field provides a measure of concurrent validity (Dallos & Vetere, 2005). This is presented in chapter 4.

Respondent validation

Respondent validation has been used in a number of different ways and at different stages of the research process. At the beginning of the pilot study I surveyed staff members in my department about topics of interest that they thought would be important when asking flexible trainees about their training experiences. I compared these with the themes that emerged from the pilot study. There was a great degree of overlap between staff predictions of important issues and those discovered in the data, providing a degree of face validity to the emergent themes. The longitudinal design allowed me to take my initial theory, following the second stage of data collection, into the final round of interviews in order to obtain feedback from participants about my interpretation of the data and to allow further collaborative exploration and theory development.

Audit trail

The audit trail has been described during the process of data analysis, which explains the derivation of the theory from the initial data. Excerpts from the transcripts illustrating the coding applied to the data and the later refining and grouping of these codes into larger categories can be traced back to the data.

Independent audit

Independent audit was also implemented through discussions of the analysis with my academic supervisor. These discussions identified areas of the theory which did not make sense in relation to the data from an independent perspective and thus identified areas of the theory which required further exploration and grounding in the data.

2.3.2.3. Transparency and coherence

Transparency

All research is potentially biased by the researcher's decisions about what to study; how to develop their research questions and go about exploring these; how to analyse their data; which aspects of the data to focus on; and how to interpret and report the results they have found (Stiles, 1993). These biases are inherent and are derived from our own personal interests and clinical, research and life experiences, as well as being influenced by the wider social, professional and political context. It could be argued that an advantage of qualitative research is the emphasis on making such biases explicit to the reader and reflecting on the impact these might have on the research process. Given my role as a flexible trainee and my relation to the participants, I have endeavoured to be as transparent as possible throughout all stages of this project, from the development of the research idea to the methods of data collection and analysis and to the derivation of my interpretations from the data and their possible implications.

Reflexivity is therefore a crucial element in this project in order to identify, describe and incorporate the researcher's subjectivities into the research process. This requires reflecting not only on related personal experiences but questioning how that experience has come about in relation to others involved in the process and within a particular historical and institutional context (Parker, 2005). The explication of the researcher's position serves to identify what it is about that position that has facilitated certain aspects of the research and what has hindered others (see section 3.2.1 for an account of the researcher's position in relation to the participants). The methods used in this study to facilitate reflexivity are described below.

Reflective diary

Throughout the research process I have kept a reflective diary to enable the separation of my own thoughts and feelings about training from those of the participants, to document my feelings about the research process and explanations of decisions made at various

stages of the project, and to document my thoughts about emerging themes and relations between themes as the theory has developed over time. I have used the diary in several ways:

Firstly, I recorded my own reflections on my developing professional identity, prior to commencing data collection, and have added to this throughout the project as my training has progressed. This is presented in the introduction (section 1.6) to orient the reader to the personal context of the research.

Secondly, I used the reflective diary to document my predictions of what I expected to hear, prior to each round of data collection in order to illustrate my stance. These predictions are also documented in the introduction (section 1.6) and evaluated in relation to the data in chapter 4.

Good practice requires investigators to disclose their expectations and preconceptions. But these are meant as orientation for the reader and as an initial anchor point, not as hypotheses to be tested. (Stiles, 1993, p.600)

Thirdly, I used the diary to record my reflections on the research process itself, in particular my thoughts about the process of data collection and analysis, and how my interactions with the data have changed my perspective. This has resulted in a clear documentation of decisions made about sampling, coding and categorisation and about the emerging theory.

Self-reflexive interview

I conducted a self-reflexive interview with a colleague to facilitate more in-depth self-reflection on my position in relation to the research project. I felt that this was particularly important, given my role as a flexible trainee and my relation to the participants. I felt that a reflexive interview about my stance conducted by a colleague would better facilitate the identification of thoughts or feelings about the research than I

myself would be able to document in my reflective journal. This interview was transcribed and used in the documentation of my stance and in the consideration of researcher bias.

Transparency also refers to the processes of data collection and analysis. I have documented these processes in detail in the section above, providing a thorough account of the step-by step process of theory generation from data collection to interpretation.

Coherence

Coherence refers to the ‘apparent quality of the interpretation’ (Stiles, 1993, p.608). It involves a comprehensive description of concepts, relations between concepts and the identification of exceptions that the interpretation does not account for. It should be internally consistent and intelligible (Elliott *et al.* 1999).

One method of assessing coherence is to examine the interpretation’s testimonial validity: i.e. is it coherent to the participants? Prior to the final round of data collection I presented a summary of my interpretations to the participants for discussion. All participants felt that the theory I presented reflected their experience accurately and that they could easily identify with it. They identified with some aspects of it more than others: some aspects of the theory did not relate to their experience but their experience was adequately accounted for within the model. This suggests that the theory sufficiently captures the variety in experience expressed by participants in the previous rounds of data collection providing respondent validation. Coherence also refers to the fit of the research methods to the research aims (Yardley, 2000). I have discussed in detail the rationale for choosing a constructivist grounded theory approach based on the aims of the research and consider this to be a good fit.

Reflexive validity, an additional measure of coherence of the interpretation, is concerned with whether or not the interpretation provided by the researcher has produced a change in their understanding. This is particularly important given my role as a flexible trainee

and someone who is immersed in this process themselves. In chapter 4 I discuss the impact that the research has had on my general understanding of professional identity development and on my personal experience of this process.

2.3.2.4. Impact and importance

Research should be useful and important (Yardley, 2000). It may present a new way of conceptualising a particular topic and as such enhance or change people's understanding and inform their behaviour or practice within the field. Some qualitative research may also have a wider social impact.

Many participants found the experience of taking part in the research empowering: they felt that somebody was interested in learning from their experiences and that their views were being heard:

The reason that I wanted to meet with you is because nobody throughout the process has listened to the people that are on the front line and going through the process of flexible training especially the first cohort...And I think this thesis will be a valuable piece of work, not only, kind of, in years to come reflecting on, you know, what it was like at the initial stages if indeed they decide to retain the flexible training (uhuh), but I think more importantly, you know, it will be a documented piece, it will be a documented piece of evidence that you, that you've created that people can't ignore...I think it's worth kind of meeting up and participating and, you know, I don't mind that at all because I do value and respect the work that you are doing, because nobody else has. (Participant A6:T3)

Participants also felt that the research was important which is demonstrated by the high proportion of the cohort who opted into the study. Stiles (1993) refers to whether or not the research has been empowering for participants as catalytic validity.

I believe that it is both useful and important to understand the process of professional identity development amongst current clinical psychology trainees in order to determine

how new methods of training affect this process. In terms of utility, the emphasis of qualitative research on the context in which research takes place facilitates a closeness of fit between research and practice. This research project's location in a local and specific context has the ability to influence aspects of the practice of training within this context where flexible training has been introduced. It might also have a wider influence on professional and academic discourse about professional identity development through the identification of factors that have facilitated and impeded identity development in this context. This may provide useful information for others when considering the effect of different training courses or approaches on the development of professional identity.

Stiles (1993) states that 'research should be believable and useful to parties beyond those who participated in doing it' (p.593). My reasons for developing the pilot study into my thesis research were greatly influenced by the response that the research received. There was a great deal of positive response to the pilot study with many interested parties seeking copies of the research to make use of the information available. It is my belief that several changes which occurred locally were influenced by or directly in response to the results of that study. In Fife Clinical Psychology Department the following changes occurred: commitment exclusively to the flexible training route; development of an in-house training committee to discuss all departmental training issues; consideration of flexible trainee roles including use of Personal Development Plans (PDPs) to promote learning and development within the work and access to opportunities for continuing professional development (CPD); and development of opportunities for flexible trainees to develop their role i.e. mentoring trainees in years below. Some of these changes have also occurred in other health boards such as commitment exclusively to the flexible training route, the use of PDPs, and greater access to training and development opportunities within the work role. There were also some initial misgivings by the course about the research, particularly given my role as a trainee. This certainly created some challenges in the research process and I have attempted to address these where possible. I have demonstrated rigour in data collection and analysis, and have been transparent and self-reflective about the research process throughout. I acknowledge a

number of advantages and disadvantages given my role as a trainee in relation to the participants and allow the reader to consider my interpretation within the social and research contexts described throughout.

Due to the constantly changing nature of the social world, grounded theories of human behavior are both preliminary and relative in context and time. I therefore present my interpretation as one perspective amongst many consistent with the constructivist approach which ‘does not seek truth – single, universal and lasting,’ rather it seeks to determine ‘what research participants define as real and where their definitions of reality take them’ (Charmaz, 2003, p.272).

3. RESULTS: DEVELOPING EQUILIBRIUM

This chapter describes the main findings and my interpretation of these findings.

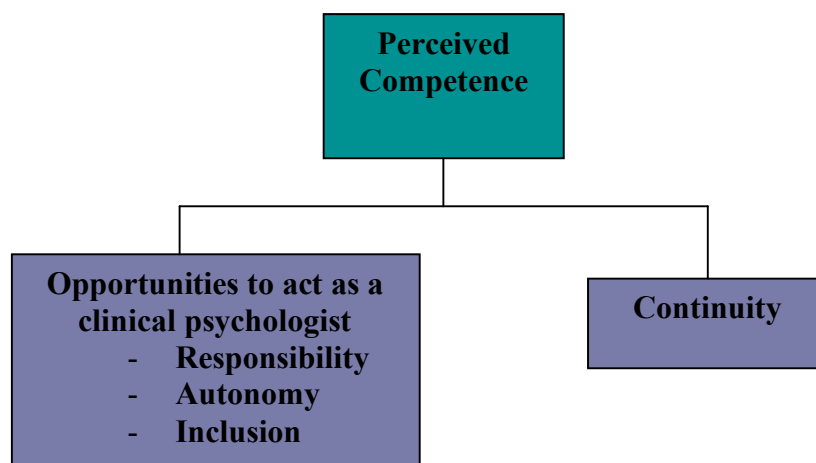
Section 3.1 describes the main categories that have emerged from the data. There are two principal categories (Perceived Competence and Formal Status) and four secondary categories (Comparisons with Others, Expectations of Others, Role Conflict and Role Ambiguity). The similarities and differences within these categories between the three groups in this study (namely flexible trainees in their 4th and 5th years of training; 3-year newly qualified clinical psychologists; and 4-year flexible newly qualified clinical psychologists) are discussed. The findings are illustrated with transcript extracts to ground the results in the data.

Section 3.2 outlines a model of professional identity development derived from my interpretation of the results.

3.1. Descriptive Results

Principal Categories

3.1.1. Perceived competence



Participants' perception of competence in their role appears to be fundamental to their professional identity development. The availability of opportunities to acquire skills and competence in those behaviours associated with the professional role, is central to the development of this perception. Continuity of experience is also important in facilitating this. These two sub-categories (opportunities to act as a clinical psychologist and continuity of experience) together constitute the principal category of Perceived Competence.

3.1.1a. Opportunities to act as a clinical psychologist

Having opportunities to assume the role of a clinical psychologist appears essential to the development of competence. During training, a considerable proportion of time is spent on clinical placements. These provide experience of the roles that clinical psychologists typically perform and facilitate the development of skills in a number of core competencies. Following their first year, in addition to the six placements completed by all trainees, flexible trainees spend half of their time in their work component providing a service contribution to a designated area of need. This additional component can potentially provide access to a broader range of experience for flexible trainees, providing opportunities to develop a wider range of skills. Examples of these skills include: managing a split post, managing waiting lists, being responsible for a particular service, representing psychology within multi-disciplinary teams and contributing to service developments. These are skills that 3-year trainees typically felt they did not develop until working in their first post after qualification. This enhanced opportunity was described by this 4-year trainee:

...I feel actually this year, I have the most wonderful opportunity to practise supervising, practise managing a waiting list, practise being the manager, the consultant, all the stuff that go along with the qualified job that you don't necessarily know about until you start working. I feel I get to do that under supervision and talk about that (yeah)...and, I feel so

lucky for that and I'm going to go into a job so much more prepared...(Participant A9:T2⁴)

In contrast, 3-year trainees appear to have more limited opportunities to assume the clinical psychologist role throughout their training due to the time-limited nature of their placements. The impact of this on their sense of competence can be seen during the transition to qualified practice.

Many of the 3-year newly qualified clinical psychologists interviewed found this transition difficult. They describe being unprepared for work and feeling as though their learning started on qualification. They attribute this to being unable to get through enough volume of work during training to feel prepared, and to a lack of training in some aspects of a clinical psychologist's role, which they now find themselves having to perform. This 3-year trainee describes her⁵ training as 'a means to an end' which suggests that her training experience did not accurately reflect the realities of work as a clinical psychologist or adequately socialise her into her professional role:

I think with that, for me anyway, comes a sense of feeling like you're at the bottom of that ladder all over again (r⁶: right) and you've got kind of, you've just, kind of, gone through all that process of being an assistant, then you're on the course and you work through all that, and then you just all of a sudden right back and you almost, for me it feels like all of that was a means to an end, just to get to this point (r: uh huh). And the learning really starts for me now (r: right) on the job... I think I've learnt more in the job in the last 7 months (umm) than I probably did in 3 years of training (r: yeah?) if I'm being perfectly honest. (Participant B4:T2)

This sense of being unprepared for the realities of work as a clinical psychologist is reflected in many 3-year newly qualified practitioners' goals for their first year:

⁴ Participant codes: A= flexible trainees; B = 3-year trainees; T1=pilot study, T2=2007; T3=2008

⁵ Participants are referred to as female throughout this chapter to allow the writing to flow more freely. The female form was chosen due to the high proportion of female over male clinical psychology trainees. This system is also adopted when quoting extracts from the focus groups and interviews. All participants and others mentioned within the quotes are referred to as female in order to protect the identity of the small number of male trainees who could be more easily identified.

⁶ r = researcher

It almost sounds like we all wanted the same thing cos I would agree I just wanted to bed in. Build my confidence clinically, get to see more [client group], get to know what I was doing. And it feels like I haven't had the opportunity to do that because I've got all this other new stuff (r: umm). I kind of resent that other stuff a bit cos I think, you're taking away the time when I was just going to enjoy my first year (r: yeah) and feel confident and you've taken that away from me. And now I'm like a gibbering wreck again with all this other new stuff that I have to worry about. (Participant B4:T2)

All 3-year newly qualified practitioners describe wanting to build on and consolidate their clinical skills before undertaking more unfamiliar non-clinical roles such as teaching, training and supervision. When they are expected to do so their sense of competence is reduced.

In contrast, all of the 4-year flexible trainees interviewed describe a smooth transition into work, which they attribute to the opportunities provided by their work components to assume roles and responsibilities akin to that of a qualified practitioner. These include having increased autonomy and responsibility for their case load, managing waiting lists and referrals, greater experience of working in teams and continuous experience within a specialty allowing them to consolidate their clinical skills:

I spoke to some full-time people last year, when they'd been in their job for a while... and they were quite stressed about it and a lot of the things they mentioned, were things I felt I was already, experiencing as a flexi trainee, (mhuh) having been in the department for three years, and (yeah, what kind?) managing. Things like, things like waiting lists...and I, I suppose they were so used to six months placements and it changing, whereas, having gone into [specialty] in my core placement in my first year, and from that point on, 'I'm here for three and a half years', you know. (Participant A9: T3)

Unlike their 3-year peers, they do not wish to delay assuming a broader range of roles; rather, they are keen to engage in teaching, training, supervision, consultancy and service development, as they feel ready to do so.

Three important aspects of having opportunities to assume the professional role were identified: having responsibility for one's work, having autonomy in one's work and being included in the department.

Responsibility, autonomy and inclusion

Flexible trainees in their 4th year and 5th year describe 'feeling qualified' due to the increased responsibility and autonomy they experience in their work components. This most often arises when they are given responsibility for a specific area or waiting list, responsibility for designing and running a particular service and increased responsibility for their work in terms of case load management and decisions regarding assessment and treatment interventions:

I think in my work, cos one of the psychologists has left, like, there's just two of us trying to mange the whole of [geographical area] so I kind of feel like I'm helping to run the service and I'm also helping with new partnerships in different areas so, I'm kind of um, I don't know I feel like I'm contributing quite a bit really. (Participant A5:T2)

Flexible trainees' increasing autonomy in their work seems to transfer to their placement practice. They describe being less fazed by new experiences and feeling confident taking the initiative with regards to certain aspects of their case management. Some flexible trainees described experiencing a degree of autonomy in shaping and pacing their professional development by feeling able to discuss their educational needs with their managers to ensure that these were met. Inclusion in departments and teams seems important to flexible trainees for symbolising their value and for differentiating them from 3-year trainees. Some consider themselves to be very much part of the department and specialty in which they work, which contributes to their sense of 'feeling qualified'. This involves inclusion in the wider work of the department; opportunities to attend CPD events and away days; involvement in setting up services and running CPD events; and responsibility for specific services or waiting lists. The above points are illustrated in the following extracts:

R: In terms of feeling competent in what you do, what has helped you to feel that way, or what has contributed to that, do you think?

Good supervision, ehm, supervision, a supervisor and a department that has been willing to let me, that's been very integrating, but then, let me be part of that department and not just a trainee and, have more of a role, take on more responsibility which has changed over my training. (right) So I was taking on more responsibility over the years. (right, ok) And giving me the opportunities to do more, non-typical trainee roles.... (Participant A9:T3)

Yeah, I think that's how it's kind of shown to me that I'm valued, is by giving me more responsibility and more autonomy. (Participant A4:T3)

Responsibility, autonomy and inclusion are described by trainees as defining attributes that differentiate the qualified clinician from the trainee clinical psychologist. It is therefore not surprising that these attributes are widely cited by both 4-year flexible and 3-year newly qualified clinical psychologists as some of the most enjoyable aspects of the job. Greater responsibility with regards to clinical decision making, freedom to act independently, and control over shaping and pacing one's own development, can increase the individual's sense of competence and ability to identify with the professional role.

Increased autonomy and responsibility imply a level of capability to perform the role independently, which can reinforce the individual's sense of competence. Qualified status also brings a greater degree of inclusion in departments, in comparison to trainee status. This includes access to CPD events, greater involvement in service and professional issues, attending strategy or working group meetings, and being privy to a greater degree of information about a wider range of issues. In addition to inferring status or value, inclusion in a wider range of departmental activities provides individuals with more opportunities to expand their range of skills and knowledge, increasing their sense of competence within the role. However, during the transition to work, differences between 4-year flexible and 3-year newly qualified clinical psychologists

can be observed regarding the responsibility, autonomy and inclusion that accompany the professional role.

Like their 3-year peers, 4-year flexible newly qualified clinical psychologists encounter challenges during the transition to qualified practitioner such as increased workload and responsibility. They describe anticipating challenges as a natural part of their work but feel competent to be able to overcome them. In contrast all 3-year newly qualified clinical psychologists describe the increased responsibility as the most challenging aspect of qualification. They contrast the ultimate responsibility that they now have for their patients and their clinical decisions to their previous role as a trainee where they were 'protected' and 'shielded' from many responsibilities. The starkness of this contrast can leave participants feeling incompetent and unable to meet the demands of their new role:

I've spent a lot of time being a student, being an assistant, being a trainee and kind of getting away with not being totally responsible for your work (umm) and not being seen as a kind of grown up fully qualified person...So I think it's a bit of a shock to the system being very autonomous and making decisions about things (yeah) that are so, you have to just deal with suicidal patients you can't go oh this patients suicidal and the supervisor kind of takes care of it, there's kind of none of that (umm) any more. (Participant B1:T2)

This suggests that, in comparison with flexible trainees, 3-year trainees have limited opportunities for increased responsibility and autonomy during their training in addition to more limited opportunities to develop the specific skills described above.

Access to opportunities to assume the professional role is therefore important for developing competence in that role. However, it is also essential that participants have sufficient continuity in their experience to capitalise on these opportunities and to consolidate their skills.

3.1.1b. Continuity of experience

Continuity of experience is crucial to the development of competence in two respects:

- 1) It enables participants to maximise the opportunities they have to act as clinical psychologists. In other words, as well as being afforded a wide range of opportunities to act as a clinical psychologist it is important that the individual has sufficient time in the role to be able to capitalise on these opportunities.
- 2) It facilitates the development of effective working relationships with colleagues and other professionals, an important aspect of the professional role.

In addition to providing specific opportunities to assume a broader range of roles, the work component provides flexible trainees with continuous experience in a particular department and specialty over three or four years compared to the isolated six or twelve month placement experiences that 3-year trainees encounter. This continuity of experience allows flexible trainees to develop their skills gradually over a period of time, taking on more responsibility and autonomy akin to that of a clinical psychologist. They have the opportunity to develop and consolidate their skills through repeated practice, greatly enhancing their sense of competence:

For me, it's gradual growth...just kind of gently unfolding the wings before you fly, if you like. It's just a little bit at a time, thinking and once you, you get feedback for that you then do a bit more and a bit more and for me that's probably how I've felt. That my competence has increased.
(Participant A15:T3)

The work component also provides greater scope for developing strong working relationships and for inclusion in departments through trainees' relative permanence and the visibility of their service contribution.

Analysis of the differences between the transition to qualified practitioner of 4-year flexible and 3-year trainees demonstrates the importance of continuity of experience for developing competence.

Many 3-year newly qualified clinical psychologists describe feeling deskilled in their role on qualification. However, those who began work as qualified clinicians in the same specialty and department as their final year of training, or in which they had previously worked, experienced a smoother transition. They had already established good working relationships with their colleagues. They were also able to prepare in their final placement for the year ahead by increasing their level of responsibility and autonomy, increasing their participation in the department and shaping their learning appropriately, in order to consolidate their skills and to enhance their competence. This continuity enabled them to prepare for the transition more thoroughly, and eased the difficulties faced by many of their peers at this time:

*...we had our jobs lined up quite a while before we finished and we knew that we were going to be working in the same area as we were training in, so I think there was much, you know, things happened. I don't know about you but, things were kind of put in place when you were still training to kind of ease that transition a bit more. Things like getting involved in the peer supervision (uh huh) that's, you know, maybe if you'd have been going on to a different health board that might not have happened.
(Participant B10:T2)*

The 3-year newly qualified clinical psychologists who experienced a difficult transition appear to have had a lack of continuity between their training and their work as qualified practitioners. They were more likely to begin work in a new department or specialty, or a specialty that they had not worked in for some time. The lack of continuity and feeling unprepared for the demands of their new role affects their sense of competence leaving them feeling deskilled:

That was the other thing about struggling to get jobs and things, is that I spent my whole final year in [specialty] (right, yeah) now I work in [different specialty]. That was a shock, I think that made me feel more

*deskilled than anything else suddenly seeing [client group] again.
(Participant B1:T2)*

This trainee spent a lot of her final year looking for a job, not securing one until a couple of weeks before the end of her training, which meant that there was no scope for focused preparation in her final year of training:

I actually thought applying for jobs got in the way of my thesis (r: yeah). I thought it was a hassle. How can they expect me to think about jobs and the future now when I'm too busy? ...I nearly had a breakdown, trying to write that thing. (No, I know, I know you were consumed) I know. So no I, I don't know, I just never thought about jobs or work. (Participant B4:T2)

This stress coupled with the dominance of the thesis in 3-year trainees' final year (described as 'being all consumed' Participant B4:T2) means that their clinical practice is relegated to their lowest priority. They focus on the more pressing priorities of their academic work and seeking employment, leaving them little time or motivation to invest in other aspects of their training. This means that few of them give thought to beginning work or preparing for it. Their third year appears to least reflect the reality of work as a clinical psychologist given the heavy focus on academic research, a role that does not feature significantly in the day-to-day practice of the majority of clinical psychologists (Kennedy & Llewelyn, 2001; Thomas *et al*, 2002). The occurrence of this immediately prior to their transition into qualified practice increases the likelihood that this is experienced as a shock because they have not been investing as much in their clinical roles during the latter stages of their training. They therefore find it difficult to adjust to the demands of their role and the wide range of tasks associated with it. This lack of continuity between training and qualified practice appears to disrupt their identity development:

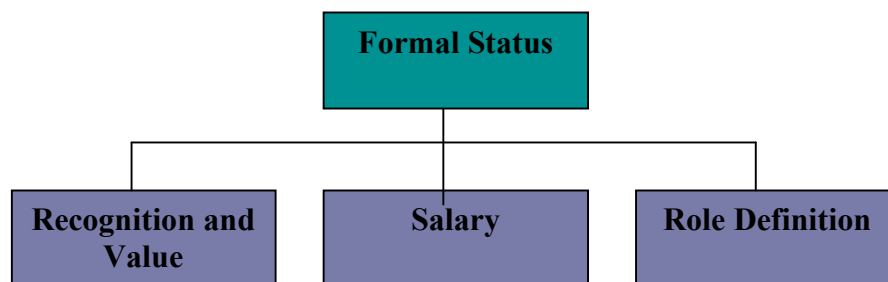
I think during my final year I couldn't see past handing in my thesis (r: uh huh). That was like the goal for me. I couldn't think about actually starting work until I had to (r: yeah) really I don't think. So it's more about finishing the course than about starting something else. (Participant B12:T2)

In contrast, 4-year flexible trainees all found the transition into work relatively smooth regardless of whether or not they remained in the same department or specialty. It seems, therefore, that the continuity provided in the work component during their clinical training enhanced their competence making the transition to qualified practitioner more manageable:

I also think, it was because of all the other stuff that I was doing, because I was a flexible, like I think, it was different. It wasn't just that I did more cases, for longer (yeah) It was all the stuff, the extra stuff that came with that like, getting to know, professionals over a long period of time, other professionals, getting to know your department, working at, you know being around. (Participant A9:T3)

In summary, where trainees have experienced sufficient continuity in their training to consolidate their skills or where trainees experience continuity between their training and their first role as a clinical psychologist, either with regard to specialty or department, the transition to qualified practitioner is much smoother.

3.1.2. Formal status



The second principal category derived from the data is participants' sense of status in their role, which I have termed 'formal status'. The formal status afforded to a role appears to be important to their professional identity development because it provides

formal recognition of their level of competence. This recognition is most clearly communicated by the professional title, although it is also communicated indirectly through other people's attitudes towards, and expectations of, them in their role. Much of the discussion between participants around their sense of status centred on their title at a given point in time and the impact this has on their work and their identity. So what is in a name and why is a title so important?

A title serves three main functions: it defines the value of an individual's work with regard to salary; it defines the responsibilities of the role; and it infers status and formally recognises the individual's level of knowledge and expertise. Both the individual's and other peoples' expectations are informed and shaped by the information that the title communicates. Others make assumptions about the individual's status, role, responsibilities, knowledge and skills based on this title.

3.1.2a. Salary

Salary is an explicit recognition of professional status and value. There has traditionally been a large gap in salary between trainees and newly qualified clinical psychologists, further emphasising the difference in status between the two positions and further emphasising the power of salary to reinforce the status of a role.

3.1.2b. Role definition

Formal status, communicated by the professional title, defines the responsibilities of the role and shapes the expectations of others both within and outwith the profession. Although there is a broad range of specific roles and responsibilities held by clinical psychologists the title communicates a shared understanding within the profession of their general scope.

For example, as clinical psychologists, participants find that their role encompasses a range of tasks. These include direct clinical work, waiting list and caseload management, contribution to departmental and multi-disciplinary team meetings, service development, committee membership, delivery of teaching and training, and the provision of consultancy. They also find that their qualified title implies a level of competence and ability to perform these wide ranging tasks. In contrast, as trainee clinical psychologists their role is to engage in the learning and development of skills necessary to become a clinical psychologist without full responsibility for and autonomy in their work. In addition to shaping expectations, a clearly defined role helps participants to differentiate themselves from others and to forge a stronger identity within that role.

Many 3-year newly qualified clinical psychologists struggle to identify with their professional role and the expectations of competence that qualified status brings as they feel it implies a level of competence that they do not yet possess:

I'm beginning to. But it's not something that I felt instantly like and I personally I'm still struggling, for me it's come up a few times recently actually with identity because I feel I've got more in common with assistants and trainees (r: right) than with qualified members of staff (r: okay). And it's almost like a conscious thing I've got to remember that I'm qualified, I'm a clinical psychologist. (Participant B4:T2)

All 3-year newly qualified clinical psychologists view themselves and refer to themselves as 'newly qualified'. This is a means of redefining the boundaries of their role and communicating their junior status within the profession in an attempt to shape the expectations that others have of them.

In contrast, flexible newly qualified clinical psychologists appear to identify more strongly with their professional role on qualification to the extent that they reject the title 'newly qualified' and do not think of themselves or refer to themselves in this way:

No, I see myself as a clinical psychologist. (uhuh) The fact that I am newly qualified, ... to me doesn't really have any bearings, I, I am a clinical psychologist whether I am newly qualified or not. (Participant A7:T3)

As this trainee describes, the title 'newly qualified' incurs certain role expectations and their rejection of it is a means of defining their role as a flexible newly qualified clinical psychologist:

I guess 'newly qualified' suggests, a three year course (right). To me, 'newly qualified' suggests that, you've just finished your six placements, your thesis, and you've been training the whole way and what that means for work is, maybe there will be a bit of leeway before you start, operating as a fully-functioning, you know, clinical psychologist.... And I guess I didn't want that leeway (yeah). I consciously want to avoid any leeway given because I think that was last year, that I had that opportunity to, you know, have a bit of breathing space, whereas now, I just want to get in and work and be part of the team and not really be given any (yeah), you know, (yeah), special privileges because I'm newly qualified, because I'm not. Or I am, but you know what I mean. [laughs] (Participant A2:T3)

This appears to occur regardless of whether or not they stay in the same specialty or department which suggests that their training has adequately prepared them for qualified practice and facilitated the internalisation of the professional role into their sense of self.

3.1.2c. Recognition and value

A title is also important for inferring status both to the individual and to others by providing formal recognition of knowledge and expertise. A title that validates participants' sense of competence enhances their sense of status and their ability to identify with their role. Conversely a title that does not accurately reflect their sense of competence contributes to feelings of lower status within the profession and a sense of lack of value and recognition.

The trainee title (that flexible trainees keep in all aspects of their work) appears to indicate relatively low status both within the profession and in relation to other professions. One participant describes herself as a 'lowly trainee' (Participant A1:T2). The lack of autonomy, clinical authority and responsibility characteristic of the trainee role in comparison with that of a qualified clinical psychologist communicates a lack of recognition of their knowledge and skill. This is problematic for flexible trainees in their 4th and 5th year because it contrasts with their sense of 'feeling qualified'. This leaves participants feeling held back and restricted in their flexible trainee role. This participant describes one such example:

One of the biggest bug bears is I've always been on the, they would have a diary and everybody has columns and down at the bottom they squeeze in the trainees (r: right) and I've always, always been down with the trainees (umm) even after 3 years. (Participant A9:T2)

The continued definition of flexible trainees' status as not yet qualified appears to undermine their sense of confidence in their abilities gained from their increasing perception of competence in their role. Kaiser (2002) describes a similar effect amongst medical students:

Having one's professional identity defined as not yet being a doctor (as compared to those ahead of oneself, such as residents or attendings) does not nourish a sense of confidence or pride in one's identity as a medical student. (Kaiser, 2002, p.98)

In contrast, the title of 'Doctor' that clinical psychologists are awarded on qualification immediately incurs status for them. Professionally it signifies their level of knowledge and expertise in their field. It communicates competence, autonomy and responsibility. It shapes other people's expectations of them and affords greater opportunities and inclusion in comparison to the title of trainee clinical psychologist. It is also personally meaningful to participants because it acknowledges their achievement and marks the much awaited end of training.

4-year flexible newly qualified clinical psychologists describe finding the title less important than they thought they would, given the lack of title other than 'trainee' during their training. They describe using the title 'Doctor' variably depending on the situation to infer status and to modify others' expectations of them. (This is most probably the case for 3-year newly qualified clinical psychologists too but was not something that arose in their discussions). For example, their title is used in all official correspondence and in communications with other professionals to clarify their level of training and expertise and to give weight to their communications. In day-to-day interactions with colleagues and patients, however, they do not frequently use their Doctoral title, because it highlights the power imbalance between patient and therapist. This 4-year flexible trainee describes her desire to eschew the hierarchy of the medical system in order to facilitate productive working relationships within a multi-disciplinary team:

But it was really odd, because I came in and just the hierarchy of things, is quite odd in that my name was put under [managers] (mm), in terms of who's in the team, on the front door and stuff and just stupid things like that, like Dr [name of line manager] and Dr [own name] (yeah) and I thought, "Oh, I wonder how that's perceived?" Because, here I am, you know still a young, 'girl' really [laughs] (laughs) Ehm, and I wonder how that, you know fresh off the course (yes). Because at the end of the day I did just qualify. [laughs]...So I thought that really needed, thought because I really didn't want to put anybody's back up (uhuh) because they all do have lots of experience. (Participant A2: T3)

Comparisons of the importance that flexible trainees place on their title during training and after qualification would suggest that choosing not to explicitly use the title in day-to-day interactions with others does not mean that it is unimportant. The title appears to be an implicit mark of achievement and of having gained a certain level of knowledge and skill. Simply having a title that appropriately acknowledges their level of competence appears to be sufficient to boost their confidence and validate their own sense of competence and achievement. This participant compares her situation now after qualification with her situation as a flexible trainee when she lacked an appropriate title:

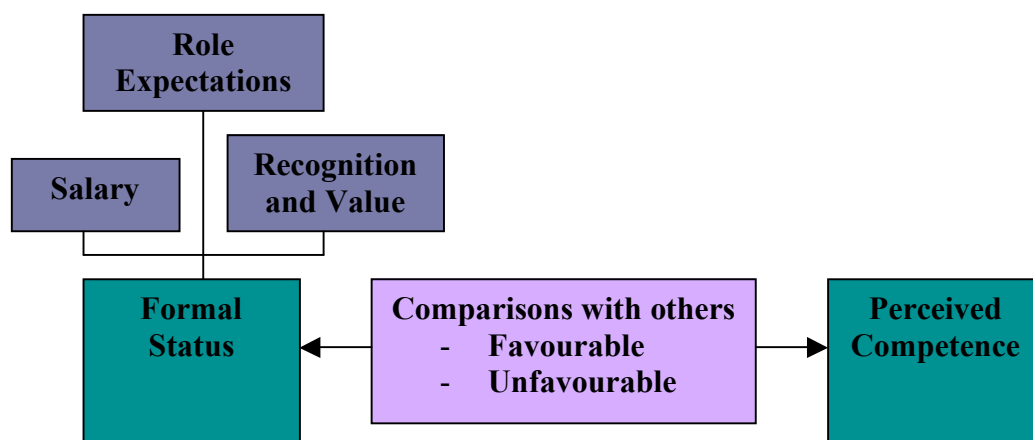
...like I have some, weight or authority behind what I am saying, (right) I've probably said the same things to people when I was training, but just by being a 'Doctor' and being unsupervised, I don't know whether, they, take it differently. I was having this kind of, thing at the beginning. It felt qualitatively different, (mhuh), speaking to people, and I couldn't decide if they saw me differently, which I think is unlikely, because some of them didn't even know me before. I think it was just, eh, I don't know, I think it was just, I think maybe gave me more confidence. (yeah) I going, rather than going, "Oh, well, this is what I think is going on, but I think I'd better check with my supervisor". (Participant A9:T3)

Ambiguity arises when roles are not clearly defined, are not adequately differentiated from others and do not adequately recognise participants' level of knowledge and skill. This is something that flexible trainees experience in their work components and throughout their training due to the lack of title other than that of trainee clinical psychologist. In section 3.1.6, this issue is explored further.

Secondary Categories

In addition to the two principal categories described above, four secondary categories were identified from the data. These are: Comparisons of self with others, Expectations of others, Role Conflict and Role Ambiguity, and are discussed in turn below.

3.1.3. Comparisons of self with others



Individuals compare themselves with others as a means of evaluating their level of ability and the level of recognition and value they receive in their role. These comparisons affect their perception of competence and of status within an organisation. If individuals view themselves favourably in comparison with their frame of reference then their sense of competence and status will be enhanced. Equally, unfavourable comparisons can damage their sense of competence or status. Comparisons along these two dimensions can differ and can impact on each other. For example, flexible trainees in their 4th and 5th years make favourable comparisons with their 3-year newly qualified peers with regard to their abilities within their role which boosts their sense of competence. However, their comparisons with their peers with regard to status and value within the organisation are unfavourable. This dichotomy creates conflict for flexible trainees.

Flexible trainees compare themselves with qualified clinical psychologists, particularly their 3-year newly qualified peers. With regards to their competence, many comment on their ability to perform 'qualified tasks' and take on a number of 'qualified responsibilities' such as managing their caseload, managing a waiting list, conducting teaching and training, managing a split post and covering vacant 'A' grade positions. They also use their frame of reference to gauge the type and range of opportunities that they feel they should have access to given their level of training and experience:

I've been able to use the incoming A grade as a template and made that explicit. I had a sit down with my line manager and my thesis supervisor and my placement supervisor and said this is what I'd like to get out of the next two years. (r: right) and if she's doing it, then I'd like to be doing it as well and so we've divvied up the, who's from the department going to represent the team when we go to the different ward meetings and things like that... (Participant A10:T2)

Their comparisons of their level of competence, then, are generally favourable. However, comparisons are also made in order to evaluate their status within the profession. For flexible trainees this comparison is unfavourable. As mentioned earlier,

the trainee title incurs certain role expectations and low status for the individual. In comparison with their 3-year peers, flexible trainees have lower status, less autonomy and less responsibility. The most explicit marker of the difference in status and recognition between flexible trainees and their 3-year peers is their salary. Flexible trainees in their 4th and 5th years are currently on much lower salaries than their 3-year peers. This situation is currently under review. Ambiguity surrounding the salaries of flexible trainees has been greatly affected by Agenda for Change, the modernisation of the NHS pay system, which has been problematic for the profession as a whole. However, this has caused considerable conflict for flexible trainees as the lack of financial remuneration for their experience signifies lack of status and recognition within the profession, leaving them feeling disadvantaged relative to their 3-year peers. They also describe experiencing lower status in their personal lives as they are unable to afford many of the things that their 3-year peers can when they graduate, such as houses and cars; this impacts on peer relationships.

Certain situations (such as working alongside newly qualified 3-year peers) exacerbate the conflict that flexible trainees feel between their perceived competence and their formal status, as such comparisons are unavoidable. Their level of competence in comparison with their peers is evident yet their trainee status prevents them from enjoying the same level of autonomy, responsibility and inclusion in their role, leaving flexible trainees feeling demoralised and undervalued, as this participant describes:

It feels as though you're working so hard, but the reward is just so far off. It's almost like delayed, you know. You're just working so hard and you are seeing other people getting recognition for their hard work, but then that recognition is still quite a way off for you, and you've still got to do more hard work before you get there kind of thing. (Participant A3:T3)

This conflict is even greater during their 5th year of training when flexible trainees find themselves working alongside 3-year newly qualified clinical psychologists who started training the year after them and who graduated a year before them. In these situations, 5th year flexible trainees describe feeling more competent than 3-year newly qualified

clinical psychologists, particularly in their work role. They describe giving advice regarding case management and different organisations and procedures, while being paid considerably less than their colleagues. In these situations they are constantly confronted with the mismatch between their level of competence and their formal status, which has a negative effect on their self-esteem and motivation within their role:

I've had that experience but it's kind of, it's more, if anything it's, kind of, making things worse (umm). Cos I think, I know more about it, I can do the job standing on my head. Here I am, stuck. (umm, umm) and that's what you think and it just kind of makes me feel quite, it's hard to get motivated (umm; r: uh huh) just to do things like on a day-to-day basis. It's really hard. (Participant A8:T2)

R: and in what way stuck?

Stuck because, well ok an example of a qualified person starting who was in our year, teaching her what tests she should do. And then the thing that pops into your head is, here I am stuck. Can't move, eh well you can't move anywhere, (umm) you've no freedom. Money wise she's earning a third more than me (r: uh huh). I'm getting my letters checked for grammar (laughter). Do you know, (r: yeah) and it, what that does is it makes you feel less confident and, kind of, you know, well that's it for me. Even though you know you're confident yourself. You're competent at what you can do. (Participant A8:T2)

It would appear then that the impact of such unfavourable comparisons on flexible trainees is a loss of self-esteem and self-confidence and decreased motivation despite feeling competent in their abilities. In contrast, 3-year newly qualified clinical psychologists describe feeling deskilled in the face of unfavourable comparisons made with more experienced colleagues. When they see themselves struggling to manage their workload or to take on specific roles, they feel deskilled and junior in status. This affects their developing sense of competence and creates conflict between their perception of their abilities and their formal status as clinical psychologists. 3-year newly qualified clinical psychologists who found the transition difficult were more likely to make unfavourable comparisons with others. What appears to contribute to these unfavourable comparisons is a comparison of themselves with others who may

have many years experience and an expectation that by being qualified they should have all the answers and take everything in their stride:

I worry why I don't keep up because I do ridiculous, I do evenings and weekends and then I think how come everybody else can finish at 5. How are they managing to do things in that hour (umm). (Participant B4:T2)

In comparison, 4-year flexible newly qualified clinical psychologists and 3-year clinical psychologists who experienced a smooth transition describe being more comfortable tolerating uncertainty and recognising and accepting the limits of their knowledge:

I think, ehm, in terms of doing the training, particularly at the start you feel, well I certainly felt as if I knew nothing, (mhuh) and I was thinking about it recently. Now I just feel as if I don't know enough. (right) I don't feel completely incompetent, (yeah) but I don't feel as if I'm totally there yet. And I think I'm getting better at living with the fact that I'll never be fully there and that that's just part of it. (Participant A2:T3)

Flexible newly qualified clinical psychologists are keen to differentiate themselves from 3-year graduates, particularly those who began training after them. Comparisons of themselves with 3-year newly qualified clinical psychologists in the year below further confirm their sense of increased confidence and competence in their role. They describe feeling less anxious, seeking less reassurance and feel more comfortable with the increased autonomy and responsibility of taking on a broader range of roles:

...my perception certainly is that, you know, when its, kind of, difficult, sort of, situations like, you know, kind of, difficult cases that, you know, they just find that it's outwith their, sort of, level of competency so I don't know it, it just, kind of, seems that I suppose that they're a bit more anxious and (yeah), you know, looking for a lot more reassurance and they, kind of, seek the advice from their line managers and supervisors... a lot more. (Participant A6:T3)

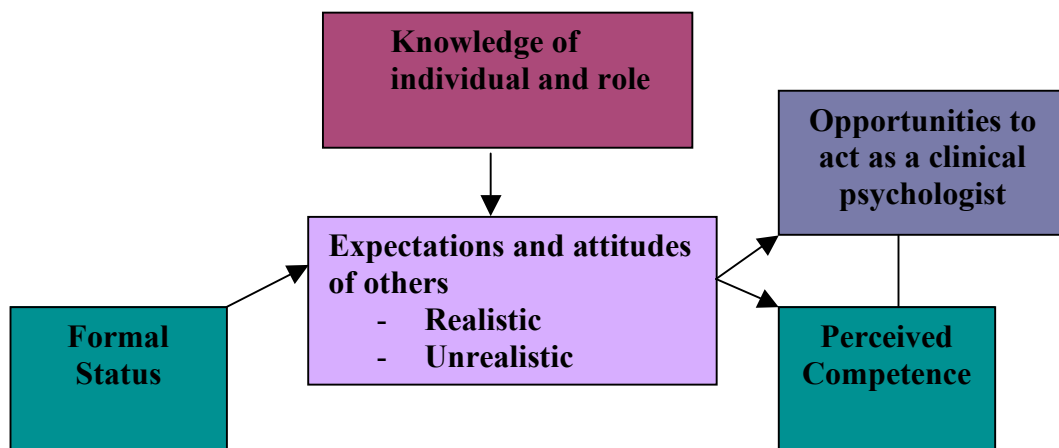
This comparison underlies flexible newly qualified clinical psychologists' motivation for rejecting the 'newly qualified' title. They consider that it does not adequately reflect

their level of training and experience and they do not want to have less responsibility or fewer opportunities simply because they have just qualified. Indeed, they wish to be seen as ‘fully-functioning’ clinical psychologists:

...I've never introduced myself as newly qualified, because I think there's a certain understanding from those words. (uhuh) They don't accurately reflect our stage of training, (yeah) so I've always avoided using that word, in the same way I avoided using 'trainee' [laughs] when I was in 4th year. (Participant A2:T3)

This, however, has the potential to create unfavourable comparisons for 3-year newly qualified clinical psychologists in the year below. This is a dynamic that I had not anticipated and would be interesting to explore further. It is possible that this comparison between ‘newly qualified’ 4-year flexible and 3-year clinical psychologists could be an additional source of conflict for 3-year newly qualified clinical psychologists, increasing the stress already associated with their transition into work.

3.1.4. Expectations of others



The expectations that others have of participants in their role are derived from the role definitions communicated by the formal status and professional title. They are also

shaped by others' knowledge of the individual and the role. These expectations determine the opportunities and responsibilities awarded to the role occupant and thus act as a mediating factor in the development of competence. If expectations seem realistic to participants and match their stage of development, then they are able to take advantage of the benefits provided by the opportunities and responsibilities afforded to them to develop competence in their role. The provision of opportunities and responsibility also signifies confidence in their ability by others which can enhance self-confidence and feelings of competence.

Flexible trainees who enjoy realistic expectations in their work and training roles describe feeling that their perception of competence and value within the profession is validated, which in turn boosts their self-esteem. Some flexible trainees in their 4th and 5th year report that in spite of realistic expectations within their work role, they experience feelings of demoralisation in response to the contradiction between inherent aspects of the trainee role and their perception of competence as a clinical psychologist. This is discussed further in section 3.1.5.

Flexible trainees in their 4th and 5th year define realistic expectations as being viewed and treated as colleagues rather than trainees, with equivalent responsibility, autonomy and opportunity for development as their 3-year peers. Flexible trainees, whose supervisors have what are considered to be realistic expectations of the flexible trainee role, appear to be afforded greater responsibility and autonomy, included more in departmental activities and able to access a wider range of development opportunities. Realistic expectations also appear to constitute an integrated view of the flexible trainee's three roles of service provider, trainee professional and postgraduate student, emphasising a balance between their training and development needs and the needs of the service. This flexible trainee contrasts her experience in two departments with differing attitudes towards and expectations of the flexible trainee role:

...I was very much a trainee and I was never involved in any CPD or anything whereas moving to [new specialty] they've signed me up for

millions of CPD and I'm very much included as a valuable member of the team. Which was, before I was labelled with the assistants and I wasn't really asked my opinion, so I don't know if that's as much to do with work as with department but certainly with my work component I definitely feel I have a lot more responsibility. (Participant A5:T2)

Realistic expectations defined by 3-year newly qualified practitioners constitute an acceptance and endorsement of the first post-qualification year as a period of transition: a time for them to build on and consolidate their skills without feeling pressured to take on unfamiliar roles that might threaten their self-confidence and feelings of competence in their role. Those who were able to do this and who felt supported in gradually familiarising themselves with their new role experienced a smoother transition from trainee to qualified practitioner. Realistic expectations are more likely when trainees make the transition within the same department. Their supervisor's awareness of their level of knowledge, and ability to adjust their expectations accordingly, means that individuals feel less pressure to present themselves as fully competent within a familiar department, than they perhaps would if they moved to a new place of work:

I suppose cos I knew the department, I knew what it was going to be like...so that's made it a lot easier I think rather than, and people, because they knew you as a trainee and now as a qualified, and rather than having to present yourself as a qualified person to a whole new department in a different kind of way I think would be, would make it harder because you'd have to feel more sure of yourself. Whereas here they're like oh yeah [name]'s back she's qualified now (ok, yeah) kind of an acceptance of that's where I was at rather than having to, I think it was harder where I didn't know people and you have to say yeah I'm [name] clinical psychologist this is what I do. (Participant B1:T2)

In contrast to their 3-year peers, flexible newly qualified clinical psychologists define realistic expectations as viewing them as competent clinicians, with considerable experience and training behind them, who are ready to assume the full gamut of roles associated with being a clinical psychologist.

If the expectations of others do not match participants' resources they are likely to be perceived as unrealistic. This occurs when either the demands of the role exceed their resources (either knowledge or time) to perform that role adequately, resulting in feelings of *role incompetence* (Hardy, 1978, p.83) or when their resources exceed the demands being made of them, resulting in feelings of *role over-qualification* (Hardy, 1978, p.83). Both of these situations lead to feelings of tension, stress and demoralisation amongst trainees. Variability in expectations appears to be largely a function of the ambiguity surrounding flexible trainees' work component. The consequences of such ambiguity are discussed in section 3.2.6.

During their 4th and 5th years, many flexible trainees describe feelings of *role over-qualification*, as their resources of knowledge and experience exceed the demands of their role as a trainee. Flexible trainees therefore consider others' view of them being the same as 3-year trainees as unfavourable and one which results in unrealistic expectations of them. When flexible trainees feel as though they are treated like trainees they describe feeling undervalued and that their extra experience is not recognised. This affects their self-confidence and creates conflict between their sense of competence and their formal status as a trainee:

It's good I think though when an area does that though give you responsibility of a specific (yeah) task and I think if, in our area it's really variable. Like some people are very conscious about the fact you're 4th year and the tasks they give you are very, kind of like, geared towards a newly qualified and not specific trainee things. But other people just still think that you can't take any more responsibility than a trainee and very set in that, and quite anti the flexible model and aren't ever gonna shift away from the fact that you can take any responsibility. (Participant A12:T2)

You don't feel valued for that, for the extra. (Participant A9:T2)

In contrast, many 3-year newly qualified clinical psychologists experience *role incompetence* during the transition to work, when they feel unable to meet the demands of their new role. Those who found the transition difficult to manage find that their

qualified status incurs expectations of competence in a broader range of activities than they anticipated, and of which they have had little or no experience during their training. They describe expecting a greater level of support in managing these demands and more time to consolidate their clinical skills and to develop confidence, prior to taking on more unfamiliar roles. Others' view of them as competent clinicians, ready to assume the full range of responsibilities associated with the role, leaves participants feeling deskilled, thus creating a sense of disequilibrium between their perceived competence and their formal status:

I think it's also about you're providing consultancy and teaching and training on the very skills that you wanted to build (yeah consolidate, that's true) and actually develop before going off to share your wisdom with somebody else (laughter). I think that's a bit frustrating I think. I don't feel up to it (yeah). (Participant B12:T2)

In direct contrast to their 3-year peers, flexible newly qualified clinical psychologists describe experiencing unrealistic expectations when others treat them and refer to them as 'newly qualified'. This participant describes feeling less pressure on qualification than in her final year of training. This provides further evidence of the ability of the work component to provide more realistic experience of the professional role for flexible trainees in comparison with their 3-year peers:

I think being a flexible trainee in a work component to a certain degree because you've been in a particular area for a while there is an expectation that you just do what everybody else does (uhuh). So I was aware that when I first, kind of, went into the qualified post it was a much slower pace and part of me was twiddling my thumbs (right) em because I had been so busy in a work role. (Participant A6:T3)

In this instance, therefore, it appears to be important that supervisors are knowledgeable regarding the flexible training model, so that they can adjust their expectations of flexible newly qualified clinical psychologists according to their level of training and experience.

3.1.5. Role conflict

Role conflict occurs when ‘existing role expectations are contradictory or mutually exclusive’ (Hardy, 1978, P.82). As discussed in chapter 1, previous research identified a number of role conflicts experienced by 3-year trainees during their clinical training. This study suggests that two main role conflicts exist for flexible trainees. These are the conflict created by their triple role of postgraduate student, trainee professional and service provider, and person-role conflict, both of which are discussed below.

3.1.5a Triple role

Analysis of the pilot study data (2005) provides support for previous findings documenting role conflict amongst 3-year trainees as a result of the competing demands and expectations of their dual role of postgraduate student and trainee professional (Cheshire, 2000b). Flexible trainees have an additional role to negotiate, that of service provider. The competing demands and expectations of these three roles result in further conflict for these trainees.

Trainees define their identity at university (during teaching and contact with the course) as one of a student, who is there to learn but who lacks freedom and power within the hierarchical institution of the university. This contrasts and is experienced as a conflict with their identity on placement as a trainee professional and adult learner who is encouraged to adopt the values of the profession in order to become a responsible and autonomous practitioner. In other words the role expectations are perceived as contradictory, as this 3-year trainee describes:

On the one hand...the way the teaching is, it's teaching you to be an NHS employee but on the other hand in order to be a good clinical psychologist we're supposed to...actually be quite a questioning, you know, somebody that's going to be far more critical and be able to go in there and do, you know what I mean, look at things differently. And I think us developing

that skill anyway in working with clients it makes you question everything else, do you know what I mean? Like on the one hand they want you to be able to do that and then on the other hand you have to fit into the box. (Participant B3:T1)

This contrast appears to be exacerbated for flexible trainees during their 4th and 5th years of training due to the increased autonomy and responsibility they enjoy during their work and training components. Flexible trainees' work components further highlight the differences between the professional and student roles because of the opportunities provided to assume a role that more closely approximates that of a clinical psychologist. As they progress through their training flexible trainees appear to identify more strongly with this role and experience greater conflict with both their student and trainee professional roles, which can undermine their sense of competence and status:

When I'm in my work component, I feel less of a trainee and more of somebody that's working (umm) and managing, you know, case loads and er, waiting lists and seeing patients and going day-to-day, but and then, every now and again you get reminded that you're not completely autonomous, that you're still supervised, that you don't have full responsibility that you are a trainee or a student... in some ways, I feel I am qualified (umm) like I do some qualified stuff but just I don't have qualified title. (Participant A9:T2)

Conflict arises between their sense of 'feeling qualified' and inherent aspects of the trainee role. Despite having high levels of autonomy and responsibility in their work components, aspects of the trainee role (such as having their letters countersigned and being evaluated) are constant and explicit reminders of their trainee status. Participants describe several experiences where this is highlighted. These include doing core placements in their final year and having to take part in the new LEPP (Longitudinal Evaluation of Performance in Psychology) evaluation scheme. In core placements flexible trainees find that supervisors' expectations of them are more likely to be lower and they are more likely to be treated like a trainee and that the LEPP evaluation project is an explicit reinforcement of their not yet qualified status:

...in some placements, for example in fourth year I did a year long placement, a specialist placement and I was treated completely like I was qualified and it was amazing and my confidence went through the roof, and it was just brilliant. And then I went to fifth year and started a core placement and was treated like I was a first year, and that's really hard because I kept wanting to prove my status, status I don't think is the word for me, ehm, level of experience, level of knowledge... And to go back to a core I think in fifth year always feels like you are back as a beginner again, depending on your supervisor it's completely, and it's like I think what [name] said that, just as your confidence gets, kind of gets built up you get a kick or get knocked down again. (Participant A1:T3)

During their 4th and 5th years all flexible trainees appear to view teaching as an unwanted interruption due to a combination of time pressures, and a feeling that their work better reinforces their developing professional identity. Returning to university is a reminder of their student status and of not yet being qualified. Their sense of responsibility in their work components for responding to service pressures and managing waiting lists means that time off for teaching, especially the longer blocks, allows pressures to accrue at work in their absence, putting more pressure on their time when they return. This responsibility for work pressures, and a sense that much of the teaching is inappropriate to their stage of training, means that teaching is viewed as an unwanted interruption thus creating internal dissonance for flexible trainees between their three roles. This is particularly marked in the latter years of their training:

I think some of the teaching comes a bit late. You know like, if you do block 5 (yeah, yeah) or something in the last year, a lot of that stuff you might of already read or picked up through the work. Like I, I did a health placement and then I've kind of got health teaching coming up and the idea of going to do that (it's daft) is, is daft. So that, kind of doesn't make you want to come back for teaching and in a way I think maybe all the teaching should be done in the first 3 years and then you carry on professional issues and like supervision training (umm; that sounds really sensible) but the core kind of 3 year teaching's done in the first bit I think would be better. (Participant A12:T2)

Some flexible trainees also describe a sense of responsibility to their work departments and a pressure to perform because they have been chosen to work there for three or four

years. They describe the need to create a good impression due to a sense of loyalty and commitment to their work component. This seems to indicate an internalisation of the work role and the responsibilities associated with it in terms of managing service pressures and contributing to the department. As a result, flexible trainees appear to have different expectations of themselves than their 3-year peers and experience a greater sense of conflict when completing their academic assignments:

My supervisor was really supportive in that and basically said that my thesis was basically the thing that got me qualified and that was the most important (right) so if I needed to prioritise that I could. But I've heard of kind of 3-year trainees having really, really small caseloads and I felt I couldn't do that because of the work component. I felt I had to keep my caseload up as well in case I was seen not to be pulling my weight because they're employing me. (Participant A14:T2)

Some describe wanting to invest more in their work roles but find this difficult due to the competing demands of their two other roles. They may be afforded opportunities but are unable to pursue them all due to the competing demands on their time:

I think as well for me it's about time again, because I think there are, kind of, opportunities there for me to supervise but there is just absolutely no time. (r: uhuh) There is, I mean there is not even admin time, so it is, kind of like, you know you can do this if you want to get involved in various projects, (r: yeah), they won't give me any time to do it. (Participant A4:T3)

Trainees also seem to feel that there is a lack of acknowledgement of their triple role and the multiple demands on their time, resulting in a lack of integration between the three aspects of their training. For example, they describe a lack of acknowledgement by the course about their responsibility to their department and contribution to the service. Similarly they describe a lack of acknowledgement of their placement and academic requirements (in particular their thesis) by managers, and a lack of acknowledgement of their work commitments by placement supervisors, as these extracts illustrate:

But I think the only thing with that is... there's an expectation of, well, you know, that other people within your cohort are qualified, so you need to be working at a qualified level and I think that there should always be a recognition that we're still doing thesis and other things as well, on top of that. (Participant A5:T2)

My placement's pretty hectic. I think there's a thing about my supervisor, who's great but they have been used to having somebody for 3 days, I think there's something about that. Even though they're fully aware that, you know, but you still end up doing quite a lot of stuff. (Participant A4:T2)

In addition to role conflict resulting from 3-year trainees' dual role, Cheshire (2000b) observed feelings of disempowerment to effect change in their training as a result of organisational and bureaucratic constraints within the course structure. 'The Course' is a complex system incorporating a wide range of roles within two diverse institutions: namely the university and the NHS. Complexity of an organisation has been identified as a source of role ambiguity (Kahn *et al*, 1964).

Flexible trainees in their 4th and 5th year describe similar feelings of powerlessness to effect change due to organisational and bureaucratic constraints. Occupying a seemingly uninfluential position between two contrasting institutions, trainees feel that their needs are easily forgotten given the different philosophies and agendas that the two different institutions hold. The lack of integration between the work and training components during their 4 or 5 years of training (due to their accountability to their NHS line manager for their work component and to the course and their placement supervisor for their training component) exacerbates flexible trainees' feelings of powerlessness within these two contrasting institutions. In response to the conflict between their different roles, trainees tend to adopt an apathetic stance opting for avoidance and withdrawal from the source of conflict where possible. This is a common response to role conflicts (Kahn *et al*, 1964). These 5th year trainees describe their response to being excluded from departmental activities as a result of their trainee status:

See for me, I think I would be more likely to withdraw (yeah). (Participant A5:T3)

I think I've given up, I, I feel as though I've almost given up on, (r: uhuh) on that, which I know that I, in part, that I contributed to it as much as I'm, (r: uhuh), you know, I'm aware of that, but. (Participant A3:T3)

If people value you, you push yourself more (yeah)(yeah) when you're encouraged to try and (it's motivating) (yeah) (yeah) and learn. It's basic psychological principles. (laughter) (Participant A5:T3)

This withdrawal is more noticeable during flexible trainees' 4th and 5th years of training. They describe a lack of motivation or commitment to be involved in the course beyond what is minimally required of them, or to contribute to the course once they complete their training, for example by providing teaching sessions.

Flexible trainees during their 4th and 5th years engage in a number of other strategies to reduce the impact of the conflict caused by their triple role. Trainees actively avoid using the title of trainee as their sense of competence increases as a means of distancing themselves from this role and its expectations. For example, trainees describe introducing themselves as being 'from the clinical psychology department' rather than using their trainee title or stating that they have worked in a particular department for three or four years. They also choose to invest more in the roles that reinforce their feelings of competence and actively avoid situations or people who reinforce their trainee status and do not acknowledge their level of knowledge and experience. For many this means investing more in their work component because they enjoy greater autonomy and responsibility.

Flexible trainees whose work component is not their area of interest, or who are not afforded the opportunities they would like in their work components to develop their skills further, are likely to invest more time and effort in their placements or the aspects of their training that most reinforce their sense of competence in the role of a clinical

psychologist. This participant contrasts the approach of both her work and placement supervisors to her training and development needs:

There's much more stuff about your development and where do we go from here. That was big in my mid-placement visit (r: right) um, I think just, my supervisor was asking, you know what do we do now? I've never had a 4 year, a 4th year trainee (r: right). You know, we need to kind of go a bit further down, but nothing like that's come from work. We're just kind of stuck. (Participant A4:T2)

3.1.5b Person-role conflict

Kahn *et al* (1964) describe person-role conflict as a mismatch between the individual's needs and values and the demands of the role. This type of conflict was only observed amongst some flexible trainees where there was a mismatch between their work component and their personal area of interest within psychology. One participant describes this as a 'miserable experience'. This extract from a focus group with flexible trainees in their 4th year illustrates the consequences of long-term work in an area that does not match their own personal interests:

Where do I start? I think to be honest with you when I um first started in, in the [specialty] . . . that I kind of, within the first sort of couple of months I realised this is, kind of, really not for me. It's [type of work], it's you know quite heart sinking stuff and eh, but instead of kind of being able to talk about that, I burnt myself out by over compensating, by trying to like it and think well I've got 2 years to go I must like this. And actually what happens is you just end up feeling that you're completely deskilled and you know nothing and you're incompetent and / (Participant A6:T2)

/losing interest in psychology (yeah) and thinking is this for me? (Participant A2:T2)

and struggling to keep your head above the water half the time. (Participant A6:T2)

In addition to feeling deskilled and losing interest in their work, they describe great resentment towards their work component, as they believe that their more specialised training has negative implications for their future career. These feelings of resentment and of being deskilled are heightened in the context of applying for jobs in a different specialty to that of the work component where most of the trainee's experience lies. This concern arises in the context of uncertainty as to how flexible trainees will be viewed by employers on qualification (due to ambiguity surrounding their role), and whether or not the specialist skills they have developed in their work components will be viewed as transferable to other specialties:

I'm a 4-year and I'll be qualifying this year, and I think the difficulty I'm having just now in thinking about roles and responsibilities is um obviously working in [work specialty] and I'm applying for jobs in [different specialty]. And I, I went from feeling that I'm doing ok, working and training, to actually feeling really deskilled when I'm thinking about going up for jobs against people who've worked the last year and a half in [different specialty]. (Participant A2:T2)

Their increasing specialisation in an area that they do not particularly like, and which they are unable and unwilling to invest so heavily in, creates tension for these trainees. They believe that this holds them back and disadvantages them, as they are unable to shape their training along the lines of their own personal and professional interests.

In response to such role strain, trainees describe active attempts to shape their training where possible in order to maximise their transferable skills by investing more in their placements to try and regain a sense of equilibrium. They note the benefits of being supported by their line managers or supervisors in this endeavour, either to create opportunities within their work component that are relevant to their personal interests, or to organise specialist placements within their area of interest. This flexible trainee describes the positive impact of doing a placement in an area of personal interest, and highlights the effect on her self-esteem and professional identity of working in an area which she did not like:

I just spent a full year in [placement same as work area] and just in um, October went back into [different placement] half time and it's fantastic. It's just great. You know, just to kind of, being where you want to be and just, kind of, you know, kind of affirm to yourself, yeah I can do this. I'm not going to give it up and work in [a supermarket](laughter). (Participant A6:T2)

Similarly, unsupportive environments can dramatically affect trainees' interest and motivation to work in a particular specialty or department as this trainee describes:

No there have certainly been times when I've thought, like other people, no I definitely don't want to work in that area but the fact of the matter is, I am interested in certain parts of the area I am and what puts me off is the lack of support that I've received, the kind of treatment and some of my experiences just make me a bit unsure and like everyone else, I'd probably like to try something else. And the areas that I'm kind of going towards are the areas that I've had really good supervision and support (yeah, r: right). The areas I'm moving away towards are when I've not had that support. (Participant A12:T2)

Flexible trainees report that this highlights the importance of matching the work component to the individual's personal interests during selection for the course. However, they identify a number of difficulties with such specialisation early on in the individual's training. Firstly, many individuals do not know what specialty they would ultimately like to work in when they begin training. Their experience is limited and having to make such a choice at this early stage in their clinical psychology career is deemed unrealistic. Secondly, due to the pressure for places in clinical psychology training, participants feel that most applicants would accept a place in a specialty they did not particularly like or have any experience in. There is therefore the possibility for individuals to experience person-role conflict throughout the majority of their training, which can have serious implications for their confidence and self-esteem as well as their motivation and commitment to clinical psychology:

And you also don't know how you're gonna, you know people say, if you didn't like the area you shouldn't have ticked the box, but it's not necessarily an area

that you don't know you don't like (yeah) because you haven't worked in that. (yeah). So you're not going to say no to an area that you may enjoy, but you're stuck with it for five years and if you don't then you've got a problem. (Participant A5:T2)

3.1.6. Role ambiguity

Ambiguity may result because information is nonexistent or because existing information is inadequately communicated. (Kahn et al 1964 p.23)

A number of different sources of ambiguity have been described: not knowing the scope of responsibilities, not knowing how to fulfil one's responsibilities and uncertainty about whose expectations to meet (Chang and Hancock, 2003; Kahn *et al*, 1964).

For the first cohort of flexible trainees, who participated in this study, there is great ambiguity surrounding their role as flexible trainees and more specifically within the work component. This is largely a result of the lack of formal title, other than trainee clinical psychologist, for their role and the lack of differentiation from 3-year trainees which signifies to them lower status and value within the profession (see section 3.1.2c). This means that flexible trainees, and others within and outwith the profession are unsure of their status, the scope of their role and their value (both financially and professionally).

This ambiguity is exacerbated by the lack of guidance they perceive from the university in shaping people's expectations of their work role, which is defined by individual line managers. They describe feeling responsible for negotiating their responsibilities with their managers themselves, but feel that they lack the relevant information or authority to be able to adequately do so.

As they progress through their training the ambiguity surrounding their role has a greater impact due to the growing discrepancy between their perceived competence and formal

status as a trainee. Their continued struggle with the impact of poorly defined role boundaries makes it difficult for them to develop their professional identity:

Well, I suppose there are kind of misunderstandings amongst colleague groups about exactly what it is we do and don't do (umm). Uh and I suppose that sort of is, is internalised to a certain extent as well (umm) and you think well, am I a sort of jobbing clinical psychologist or am I, you know, a student, a trainee, um cos those two things seem to have different connotations as to what you should be doing. (Participant A13:T2)

The lack of formal status of the flexible trainee role means that trainees infer their status from the way they are treated by others and the expectations that others have of them. Being the first cohort of flexible trainees, they have no other frame of reference than their 3-year peers. In this context their sense of a lack of differentiation from their 3-year peers is a further source of ambiguity, which becomes increasingly salient in their 4th and 5th years following the graduation of their peers:

A new trainee came into the department and said to me, what, we were just talking about other things, what is your flexi component in? And I was like here in [specialty]. And I think she, I realised that there was actually nothing that made me look like I wasn't just on a placement doing my own work, (umm) from the outside. (Participant A9:T2)

In addition to a lack of a clearly defined role and a lack of differentiation in their work roles, flexible trainees describe ambiguity within their training and academic components, surrounding what is expected of them in these roles as they progress through their training. They attribute this to the difficulties they encounter with the application of the 3-year model over four or five years without sufficient adaptation to take into account their differing roles and the demands on their time:

I hadn't had a mid-placement visit or anything like that and I didn't know what my contact numbers were supposed to be, because were they supposed to be the same as what you did when you were in your first and second year placements and you were working four days a week? But then

3rd years who only worked three days a week didn't seem to have those same requirements for placement numbers. And basically I just didn't know what was expected so I guess I was kind of erring on the side of caution by trying to make sure that I wasn't slacking. (Participant A14:T2)

The ambiguity surrounding their role, then, not only makes it difficult for flexible trainees and their managers to know what is expected of them, but it also makes it difficult for other professionals to understand their role. Cheshire (2000b) found that the trainee clinical psychologist role was often misinterpreted by other professionals resulting in an under-estimation of their level of knowledge and experience. This creates conflict for all trainees between their level of competence and the expectations that others have of them based on the formal status of their role. This misinterpretation of the trainee role by other professionals creates more tension for flexible trainees in the latter stages of their training as the gap between their competence and formal status widens. They appear to become increasingly frustrated by the trainee title in their 4th and 5th years because it does not reflect their level of knowledge and skill and does not incur appropriate expectations from others as these participants describe:

I had a patient last week who, I sent out an assessment letter and they phoned in to say that they didn't want to see a trainee, they wanted to see somebody qualified and I was like 'oh, my God, you must be joking'. (Participant A4:T3)

I was working with a community mental health worker who was telling me about attachment and telling me which books I should read (laughter) ([name]the attachment Guru) (laughter). They just don't know where to place you, they just don't understand that, you know, you might have been here for ten years or more (laughter) (r: yeah), and have a few degrees (r: yeah). (Participant A17:T3)

The ambiguity surrounding the trainee role for members of other professions appears to affect flexible trainees more when they are working alongside newly qualified 3-year peers for example, within a multi-disciplinary team. This participant describes the disequilibrium that the lack of understanding of the flexible trainee role by other

professionals created between her perception of competence in her role and the formal status awarded to her as a trainee. She describes having more experience in the specialty and the team than her newly qualified 3-year peer but was seen as more junior due to her trainee and not-yet-qualified status:

When I was doing my flexible training work component in that team, (right), and then [name] came along as a three year, (uhuh), newly qualified, (yeah), Doctor, (yeah), and I was still in, in the training role and there certainly were a couple of times where I felt that my competence and experience didn't count for anything. (uhuh), Because now [name] was there and she was the one who was, I supposed perceived to be the senior one, (ahah), even though the reality is that I have much more experience in [specialty] than she does, (yeah). Ehm, so yeah it does create conflict and I suppose finding ways of managing that is quite difficult. (Participant A7:T3)

Ambiguity can therefore result in feelings of frustration and a lack of value and acknowledgement of the individual's knowledge and skills. In response to this, flexible trainees describe feeling as though they have to justify themselves to others in an attempt to emphasise their level of skill and experience in comparison with their 3-year peers:

I suppose I'm more aware of it when, say in team meetings or something and there is a 3rd year trainee as well in our department who has been on the 3-year model and they don't really understand why I'm still training and she's not. (uh huh) and in some ways you kind of do get that whole thing of wanting to kind of justify yourself and say it's not cos I'm any worse that I have to train for four years. I guess that's probably when it comes out most...when you're feeling you have to justify that you're just as good as somebody else, when actually you've been training for longer so you're probably a bit more experienced, I think that's, that's difficult. (Participant A14:T2)

In addition to misconceptions of the scope of their role and responsibilities by supervisors and other professionals, and lack of acknowledgement of their role, flexible trainees describe great uncertainty as to how others will view them and their experience on qualification. With a lack of formal recognition, there is concern that their extra year

or two of experience will not be acknowledged, and that they will be disadvantaged financially and treated like a 3-year newly qualified clinical psychologist, particularly in locations not familiar with flexible training. This participant describes some of the concerns shared by many of her colleagues:

Where they don't really know what's the difference and, you know, trying to say, there is a difference. Well what is it? You know cos I think somebody was saying if you, I wanted to start in January after a break, and they said if you want to start in January but somebody at your same level, wants to start in October, they'll get it. And I was thinking there's only another 8 people at my level so how many of them are going to go for the job, but that's not what they meant, clearly, um they meant newly qualified and I think my worry is, that's how we're going to be seen. That's how we're going to be paid and that's how we're going to be, you know, valued. (r: yeah). So what does this extra year or 2 mean? (Participant A2:T2)

Role ambiguity therefore can affect trainees' opportunity to develop competence because it influences others' expectations of them and thus the opportunities available to assume the professional role. Where there is ambiguity and lack of role definition trainees are more likely to use others as a frame of reference for evaluating their competence and status, the impact of which was discussed in section 3.1.3.

3.2. A model of professional identity development

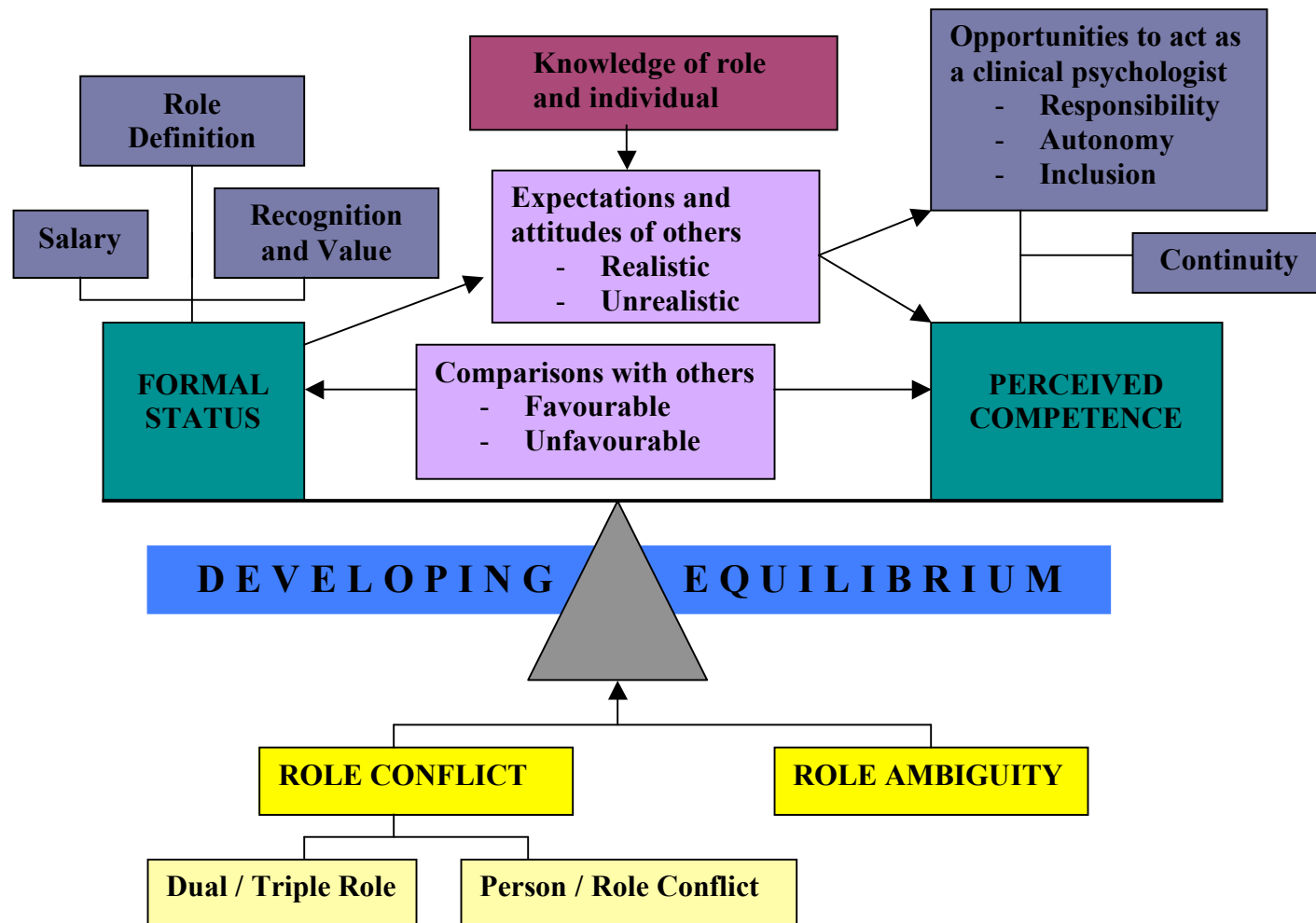
Cheshire's (2000b) study into professional identity development in clinical psychology trainees identified stages in the development of mastery reflecting a sense of competence in the professional role at the end of training. However, many newly qualified clinical psychologists struggle to identify with their professional role on qualification. They describe feeling unprepared for the realities of work, which suggests difficulty integrating the role into their sense of self on qualification. This study proposes a model of professional identity development (figure 1) that incorporates the development of both new role behaviours and new views of the self, resulting in clinical psychologists

who, during the transition from trainee to qualified practitioner, are able to integrate their new professional role into their sense of self. Comparisons of the experiences of flexible and 3-year trainees have identified these factors and the data would suggest that flexible trainees are better able to identify with their professional role on qualification.

At the core of this model of professional identity development is the relationship between individuals' perceived competence in their role and the formal status awarded to that role. In order for individuals to identify with the professional role they need to develop competence in it. This means that they require sufficient opportunities to assume the professional role, and appropriate levels of autonomy, responsibility and inclusion for their level of training and experience. It is also important that they have sufficient time to be able to capitalise on these opportunities to consolidate their skills and feel confident in their abilities. A sense of competence in a role is not sufficient to be able to identify with it. It is also important that the formal status of a role validates the individual's perceptions of competence. The formal status of the role, most explicitly stated through a title, defines the range of responsibilities, the salary, and value and recognition awarded to that role.

Whether or not the role is internalised depends on whether or not there is equilibrium between the formal status of the role and the individual's perceived level of competence and ability to meet the role expectations. Flexible and 3-year trainees experience differing levels of identification with their roles at different points throughout training and in the transition to work. This sense of identification is largely influenced by the relationship between their perceived competence and the formal status of their role.

Figure 1. A model of professional identity development



All 4-year flexible newly qualified clinical psychologists identify strongly with the professional role on qualification. They seem able to integrate this role into their sense of self because they experience a sense of equilibrium between their formal status as a clinical psychologist and their perceived competence in that role. During their 4th and 5th years of training, however, flexible trainees experience a sense of disequilibrium between their formal status as trainees and their perceived competence, resulting in a sense of over-qualification for the role. This occurs due to unrealistic expectations of others, unfavourable comparisons with their 3-year peers, role conflict resulting from their triple role, person-role conflict, and ambiguity surrounding their roles as flexible trainees. When there is disequilibrium, individuals find it difficult to identify with their role. Although flexible trainees experience difficulties with their identity throughout training, this does not appear to impair their ability to identify with the professional role on qualification.

Some 3-year newly qualified clinical psychologists (who experience a smooth transition to qualified practice) also experience a sense of equilibrium between their formal status as a 'newly qualified clinical psychologist' and their competence in that role. Providing others' view of them is one of a newly qualified practitioner, who requires time and support to consolidate their clinical skills prior to assuming the broad range of roles associated with a clinical psychologist, then they feel competent enough to meet the demands of their new role.

Some 3-year newly qualified clinical psychologists, however, experience a sense of disequilibrium between their formal status as a clinical psychologist and their sense of competence in that role. This occurs due to 'unrealistic expectations' of others that they should function as fully competent clinicians, ready to assume the full range of roles of a clinical psychologist; unfavourable comparisons of themselves with other qualified clinicians; lack of sufficient opportunities to assume the professional role during their training; and a lack of continuity between their training and their work due to the dominance of their thesis in the final year.

This model reflects the symbolic-interactionist perspective described in chapter 1. Individuals' inner experience of disequilibrium between their perceived competence and formal status is influenced by both their interactions with others and the meaning they assign to these interactions (represented by the expectations of others and their comparisons with others), and their interactions with the wider system or environment (aspects of which create role conflict and role ambiguity).

4. DISCUSSION

This chapter discusses the findings in relation to the existing literature and the socio-political context of clinical psychology training. Section 4.1 presents my personal reflections on the research process and the impact this has had on my understanding of professional identity development. Section 4.2 re-examines the results in relation to the initial research questions presented in Chapter 1, followed by their potential implications in Section 4.3. Finally, section 4.4 presents the methodological limitations of this study and directions for further investigation.

4.1 Personal reflections on the research process

Autoethnography involves connecting the researcher's personal experience to the cultural setting of the research (Ellis & Bochner, 2003). My being a member of the group studied in this research necessitates a description of the similarities and differences between my own experience and the findings presented in this study. I refer back to my own sense of professional identity development documented in chapter 1 and consider how my perspective has changed through this process.

Like many of my flexible trainee peers I experienced a sense of disequilibrium in the latter years of my training between my sense of competence and my formal status. Despite my work component being my area of interest, enjoying increased autonomy and responsibility, being included in the department, and building competence through having sufficient time to consolidate my clinical skills, I felt lacking in status at times and experienced conflict between my three roles. This conflict occurred when I was reminded of my student status i.e. at university or when being evaluated on placement, as a result of the trainee title and having my letters countersigned in my work. At these times I felt demoralised and frustrated. This affected my motivation for my different roles but did not affect my sense of self-confidence, self-esteem or commitment to psychology. In contrast, other flexible trainees' work components were not their area of

interest or did not provide as many opportunities for autonomy, responsibility or inclusion as they would have liked, yet they managed to develop competence in their role. Whilst I was more inclined to invest in my work component, these flexible trainees invested more in their placements. Their negative experiences in their work, characterised by a greater degree of role conflict, appear to have affected their self-confidence, self-esteem, and their interest in and commitment to the organisation but not their sense of competence. Role conflict amongst flexible trainees therefore seems to affect their sense of identity during training due to the increasing contrast between their three roles. It has varying psychological impact, depending on the degree of conflict, but does not affect their sense of competence. In contrast, the conflict experienced by 3-year trainees between their student and trainee roles, particularly in their final year, appears to disrupt their development of competence, manifested in a disconnection between their clinical and research roles.

Another source of conflict described by many of my flexible trainee peers was unfavourable comparisons with others. During my 4th year, I was not confronted with direct comparisons in my work or placement setting. In contrast, some flexible trainees were working alongside their 3-year peers in their work components which highlighted to them the differences in status, responsibility, autonomy and formal recognition. The importance of comparisons with others and the expectations of others to individuals' ability to develop equilibrium between their formal status and their competence were unanticipated. I identified more with these factors during my 5th year when I found myself working alongside newly qualified clinical psychologists who began their training after me. I had more experience than them in my work component yet was being paid considerably less. I was confronted with this discrepancy on a regular basis and it affected my self-esteem at times. However, this feeling has abated over time, for a number of reasons. Due to the competing demands on my time and the more prominent role of my research lately, I have been less involved in the department and therefore have been able to distance myself and avoid situations where I would be confronted with this discrepancy. Unlike some of my flexible trainee peers who

describe trying to avoid their 3-year peers as much as possible, I formed a peer supervision group with the 3-year newly qualified clinical psychologists and a 4-year flexible newly qualified clinical psychologist, which has reinforced my positive view of my competencies in relation to theirs. Also, securing a band 8a job, knowing that my experience will be recognised when I qualify, has greatly helped me to reconcile myself with the current situation.

I predicted that flexible newly qualified clinical psychologists would feel more competent during the transition to qualified practice. However, the results suggest that they also identify more with the professional role. Their rejection of the newly qualified title, in contrast with 3-year newly qualified clinical psychologists' endorsement of it, demonstrates this claim and is an interesting discovery that I had not anticipated. The differences in 3-year newly qualified clinical psychologists' transitions were largely influenced by others' expectations of them and support for the newly qualified role.

Conducting this research has required me to look beyond my own experience of training and consider a range of other perspectives on this process. This has enabled me to understand my own experiences better, through reflecting on them and comparing them with others'. Such realisations, brought about through encountering different experiences, helped to orient me within the research process to seek out and explore experiences that were different from my own. I experienced first hand the ability of differences to shift perspective and enhance one's understanding. Increased awareness of the environmental and relational influences on my internal experience has helped me to make sense of the various conflicts or tensions that I have experienced during my training. It seems possible that this knowledge and close reflection has enabled me to effectively negotiate my way through training by providing a framework for and constructive means of understanding my experience.

4.2 A review of the results and the initial research questions, within the theoretical and socio-political context.

Central to the model presented in chapter 3 is the relationship between the individual and the wider system. It therefore integrates individuals' perceptions of themselves in their roles with their perception of their role within the wider system. Some categories (e.g. perceived competence) mainly represent the individual perspective, whilst others (e.g. formal status) incorporate both individual and systemic perspectives. As such the following discussion of the initial research questions integrates both of these levels of understanding.

1) How does the work contribution in their designated clinical specialty affect the mastery of clinical skills and self-confidence of flexible trainees in comparison to 3-year trainees?

The results suggest that flexible trainees develop a greater sense of competence in the professional role during their training in comparison to 3-year trainees, and are better able to identify with it on qualification. This supports Cheshire's (2000b) findings identifying competence in the role as an essential condition of professional identity development. The work component enhances flexible trainees' competence by providing greater opportunities to assume the professional role and for increased autonomy and responsibility. This finding similarly supports research in other professions, emphasising the central importance of 'role-playing', autonomy and responsibility in the development of competence in the professional role (Bucher & Stelling, 1977; Gregg & Magilvy, 2001; Melia, 1987). Increased inclusion in departments, provided by the work component, also enhances trainees' sense of competence and professional identity through providing them with more opportunities to make a valued contribution, a finding noted by Swanwick (2005) amongst junior Doctors.

This study identified another important factor in the development of competence not specified in the literature: continuity of experience. Many 3-year trainees describe a disconnection between their training and their work roles due to the dominance of the thesis and their preoccupation with finding employment during their final year. These competing demands create a lack of continuity of experience, which appears to impair their professional identity development.

It could be argued that flexible trainees have more competing demands on their time, in comparison to their 3-year peers, as a result of their triple role. However, their thesis appears to be better integrated into their working week. Despite having three roles to fulfil, the integration of their research and clinical responsibilities seems to more accurately reflect the challenges faced by many qualified clinical psychologists of fitting research activity around the demands of their clinical roles (Kennedy & Llewelyn, 2001; Thomas *et al.* 2002). Whilst this causes stress with regard to time-management, it perhaps facilitates greater identification with the professional role on qualification, by providing more realistic information about the challenges of managing the clinical psychologist's wide range of roles.

There have recently been changes to the thesis model within the Edinburgh course, aimed at encouraging trainees to begin their research earlier and to publish their work. A modular design, with earlier submission dates for some chapters and the inclusion of a journal article, could encourage greater integration of research and clinical roles. However, it seems likely that 3-year trainees will continue to devote much of their final training year to their thesis at the expense of their clinical role because they are allocated more time for research in this period. The tasks of data collection, analysis, writing of results and discussion chapters, and a journal article are still likely to exert great demands on their time. I would therefore hypothesise that the thesis will continue to play a dominant role in 3-year trainees' final year and that they will continue to experience a lack of continuity between their training and work roles, thus limiting their ability to develop competence in all aspects of the professional role.

2) How does the work contribution in their designated clinical specialty affect flexible trainees' views of themselves as clinical psychologists in comparison to 3-year trainees?

It would appear, then, that the work component provides flexible trainees with greater opportunities to develop new role behaviours than their 3-year peers. However, the generic literature suggests that professional identity development is also dependent on the development of new views of the self (Glaser & Strauss, 1971, Gregg & Magilvy, 2001). Flexible trainees' enhanced ability to integrate the professional role into their sense of self on qualification over their 3-year peers suggests that the work component increases professional role identification as well as competence in professional role behaviours. This supports Swanwick's (2005) claim that professional identity development amongst junior Doctors is more about *being* than *doing* and flexible training seems to provide greater opportunities for *being* than the 3-year model.

3-year trainees' description of being 'protected and shielded' as trainees from many of the responsibilities of qualified practitioners is supported in the clinical psychology literature (Tams *et al*, 2002). For many flexible trainees, aspects of the work component, such as increased responsibility and autonomy, contribute to a view of themselves as clinical psychologists. Their description of 'feeling qualified' in their 4th and 5th years indicates greater internalisation of the professional role during their training.

This internalisation is also manifest in flexible trainees' more realistic expectations of the transition to work and their attitude towards the certainty of knowledge. Flexible newly qualified clinical psychologists seem to expect stress in their new role and appear better practised at managing it. They also seem to have more realistic expectations regarding the limits of their own knowledge and of their field, in comparison with their 3-year peers. Whilst individuals have different personal thresholds for tolerating ambiguity and uncertainty, a greater capacity for this is considered crucial to professional socialisation (Lingard *et al*. 2003; Knight & Mattick, 2006). The work

component can therefore foster flexible trainees' view of themselves as clinical psychologists, as it more realistically reflects this role. Whilst this serves to boost their competence during the latter stages of their training, and enables them to integrate the professional role into their sense of self on qualification, it creates conflict during their 4th and 5th years due to the stark contrast with their trainee and student roles, which is discussed below.

3) How might the experience of flexible training affect the transition from trainee to qualified practitioner?

Olesen and Whittaker (1968) describe internalisation of the professional role amongst nurses occurring when:

An equilibrium seemed to exist between self-expectations, self-concepts and the identity definitions exuded by the social environment. The student felt that she had a place in nursing, that for the first time she was a nurse. (p.266)

Differences between flexible and 3-year trainees' ability to develop equilibrium between their sense of competence and the formal status and expectations of their professional role, were observed during the transition from trainee to qualified practitioner.

The sense of being unprepared for the realities of work as a clinical psychologist, described by a number of 3-year newly qualified clinical psychologists, is a common finding in the literature (Cheshire, 2002; Clare & Porter, 2000; Tams *et al.* 2003). The disequilibrium between their own perception of competence and the formal status of their role results in feelings of *role incompetence*. This comes as a shock to participants because they expect their training to have prepared them for this transition. Kramer (1974) describes this phenomenon amongst graduate nurses as *reality shock*:

...the specific shock-like reactions of new workers when they find themselves in a work situation for which they have spent several years preparing and for which they thought they were going to be prepared, and then suddenly find that they are not. (p.vii-viii)

As identified by Cheshire (2000b) *reality shock* was not found amongst all 3-year newly qualified clinical psychologists: some participants in this study experienced a smooth transition to qualified practitioner. However, closer examination reveals that they struggled to identify fully with their clinical psychologist role. These participants identified strongly with the title ‘newly qualified clinical psychologist’ and described feeling comfortable and competent in this role when the attitudes and expectations of others reinforced this view. They were able to develop equilibrium between their formal status as newly qualified clinical psychologists (and the associated role expectations) and their competence in this role. *Reality shock* was also minimised by greater continuity between training and work (through staying in the same department as their final year placement) and a degree of preparation for qualifying, through increased opportunities for greater responsibility, autonomy and inclusion in their final year.

Conversely, those who experienced a difficult transition found that the expectations of others did not support their view of themselves as newly qualified; rather they experienced an expectation of competence in a broader range of roles than they had anticipated. A lack of continuity between training and work, characterised by a move to a different health board or specialty on qualification, contributed to the difficult transition because they felt more pressure to present themselves as competent clinicians. They therefore struggled to achieve equilibrium in this context.

Reality shock was not found amongst 4-year flexible trainees. This suggests that they identify more strongly with the professional role on qualification in comparison with their 3-year peers. This is most clearly demonstrated by their rejection of the title ‘newly qualified’ which serves to shape others’ expectations of them as competent clinicians. The flexible training model therefore appears better able to foster professional identity development.

4) Do flexible and 3-year trainees experience the same degree of role conflict and ambiguity? What factors influence this?

It would appear that flexible trainees experience additional role conflicts and greater role ambiguity than 3-year trainees. All trainees struggle to manage the contradictory expectations of their student and trainee professional roles. The course reinforces trainees' student roles, and their relationship with it appears to deteriorate the further they progress through their training. A sense of disenchantment with the course is common amongst clinical psychology trainees. Bender (1995) reports that 'the notion of "do what you're told and you'll pass" (p.40) 'maintains child-like behaviour' and is a function of clinical psychology training courses' 'attempt to retrogress the trainees to the role of undergraduate students' (1995, p.39). Jackson (1970) argues that the organisational structure of many professional training courses, with universities as the 'primary legitimating institutions' characteristically creates tension between the role of the university and that of professional organisations. Within this culture, the academic components appear to become a means to an end for trainees, something which is necessary to obtain their qualification but which has little day-to-day value or meaning for them. This reflects the conflict that exists between integrating theory (presented within academic institutions) and practice (i.e. their day-to-day clinical work) central to the scientist-practitioner debate within the profession outlined in section 1.2. Gillmer and Markus (2003) call for a need to legitimise reflective practice in clinical psychology training to facilitate greater integration between theory and practice. They argue that reflection on personal and professional development 'is central to the notion of the reflective practitioner, but remains peripheral to the real training issues, which lie in the domain of the scientist-practitioner' (p.20) which they attribute to the difficulty in objectifying outcomes for evaluation.

The prolonged nature of this role conflict for flexible trainees affects their ability to identify with the professional role during training. Whilst the work component provides them with greater opportunities (in comparison with their 3-year peers) to assume the

professional role and develop competence in it, it paradoxically creates greater conflict for them during their training. Holding three simultaneous roles, with contrasting expectations, means that flexible trainees are constantly reminded of their not-yet-qualified status. This undermines their sense of competence resulting in disequilibrium between this and their formal status. Becker *et al.* (1961, p.420), in their seminal study on professional socialisation amongst medical students, found that:

Students do not take on a professional role while they are students, largely because the system they operate in does not allow them to do so. They are not doctors and the recurring experiences of being denied responsibility make it perfectly clear to them that they are not.

Flexible trainees' 4th and 5th years of training therefore appear to be characterised by a sense of role over-qualification. This disequilibrium is caused by ambiguity surrounding the flexible trainee role as well as person-role conflict and conflict associated with the triple role (described above).

Cheshire (2000b) described a sense of conflict amongst 3-year trainees in their 3rd year who struggled with the lack of differentiation between themselves and 1st year trainees. It is not surprising, then, that the title trainee clinical psychologist (and its associated expectations) is problematic for flexible trainees in their 4th and 5th years. This continued designation of being not-yet-qualified impedes their professional identity development during training.

The role ambiguity that flexible trainees experience has implications both during their training and in the transition to work. During training the lack of title and lack of differentiation from 3-year trainees seems to affect their self-confidence and sense of identity development because it symbolises a lack of acknowledgement and formal recognition of their extra experience and their service role. The NHS pay reform system, Agenda for Change, has exacerbated these difficulties. There is currently wide variation between departments in the salaries awarded to clinical psychologists with

many qualified clinical psychologists salaries banded lower than is deemed appropriate by the profession. Ambiguity surrounding the flexible trainee role means that they, like many qualified clinical psychologists, have been banded lower than expected. The implications of this are discussed in section 4.3.

Participants' description of their reluctance to use the title 'Doctor' in day-to-day interactions can best be understood within the wider professional context. This view perhaps reflects wider issues regarding inter-professional relationships and the efforts of the profession to differentiate itself from the dominance of psychiatry and the hierarchies of the medical model, within which the title 'Doctor' has connotations of status and power over other professions (Pilgrim & Treacher, 1992). In day-to-day working with other health professionals, participants want to eschew the title in order to remove any power imbalance and to foster productive working relationships. However, in communications with other Doctors within the medical system, the title is important in elevating the clinical psychologist to a position of higher status and more equitable power in relation to their medical colleagues. This demonstrates the importance of an appropriate title in certain contexts. During training, the lack of a different title for flexible and 3-year trainees, exacerbates the ambiguity surrounding their role for others within and outwith the profession. Where such ambiguity exists, flexible trainees have no means of elevating their status to (what they consider to be) its appropriate level in order to influence others' behaviour towards them.

Role ambiguity appears to have more wide ranging consequences than role conflict. Ortquist and Wincent's (2006) meta-analysis of the prominent consequences of role conflict and role ambiguity in a range of organisations identified poor organisational commitment, job dissatisfaction, a propensity to quit and tension as the most significant. Other consequences associated with role ambiguity include emotional exhaustion, depersonalisation, reduced personal accomplishment and reduced job performance.

Within this study flexible trainees exhibited reduced organisational commitment and job dissatisfaction. During their 4th and 5th years, they chose to invest more time in their clinical roles (or roles which reinforced their sense of competence and status) and NHS departments, and, where possible, distanced themselves from involvement in the course due to its reminder of their student status. Those trainees experiencing person-role conflict (when the work component did not match their personal area of interest) described greater job dissatisfaction and a decreased sense of commitment to psychology.

Although increased propensity to quit has been commonly associated with role conflict and ambiguity, this appears to be an unlikely consequence amongst clinical psychology trainees, given the importance of clinical training for their future careers and the great amount of personal effort they have invested in both getting a place on the course and throughout their training. Interestingly, the finding in the literature that role conflict does not affect individuals' sense of personal accomplishment is supported in this study by flexible trainees' ability to maintain their sense of competence during their 4th and 5th years in the face of increasing role conflict.

Flexible trainees described high levels of tension resulting from role conflicts and ambiguity which was manifested in a lack of self-confidence, loss of self-esteem, sense of demoralisation and lack of motivation. However, in spite of high levels of ambiguity and conflict during their training, flexible trainees appear to be able to identify strongly with the professional role on qualification, because, at that stage, they achieve equilibrium between their formal status and their perceived competence.

This would suggest that flexible trainees would be better able to identify with their role during the latter stages of their training if the disequilibrium between their perceived competence and formal status could be reduced. This would involve role clarification, role differentiation from their 3-year peers and formal recognition of their extra

experience. This could help reduce the negative consequences of role conflict and role ambiguity which would be beneficial both for the individual and the organisation.

4.3 Implications and recommendations

There are a number of possible implications of this research.

1) Increased acknowledgement of and discourse about role conflicts and role ambiguity

Articulation and explicit discussion of conflicting roles has been found to reduce ambiguity amongst social workers (Jones, 1993). Reframing ambiguities surrounding the flexible trainee role as a conflict between their student, trainee professional and service provider roles is important for clarifying the aspects of these roles that create difficulties for trainees and for shaping their interactions with others. This research is therefore important for raising awareness, amongst supervisors, trainers and managers, of the conflicts that exist for trainees.

In order to address these conflicts, consideration of the impact of systemic influences including the organisational, political and historical context on training is vital, as is articulation and discussion of other stakeholders' experiences of flexible training. A broader perspective and increased contextualisation of the difficulties identified by clinical psychology trainees can enhance understanding, which in turn enhances the possibility of making meaningful and workable changes. This requires open discourse and communication amongst relevant parties to promote collaborative resolution of conflicts and ambiguities where possible. For example, the recent development of Fife Training Committee provides an open forum for discussion of training issues from all perspectives. Members include supervisors, service managers, trainees and local course tutors representing a range of parties connected to the training of Doctoral and MSc

trainees and has prompted a number of local changes aimed at reducing some of the difficulties faced by supervisors, managers and trainees.

Ikiugu and Rosso (2003) found that the introduction of a generative discourse on the philosophical underpinnings of theory and practice in occupational therapy training was an important factor for student's ability to develop a clear identity. During my training, I experienced little formal teaching or discussion around the socio-cultural and historical context of clinical psychology, much of which I have learnt instead through conducting this research and which has enhanced my understanding of the profession today and the training context. There is perhaps scope for this within the Edinburgh clinical psychology training course to enhance trainees' understanding of the contextual influences on their training and the conflicts and ambiguities they experience.

2) Clarification and formalisation of career paths of flexible and 3-year trainees.

The greatest problem described by flexible trainees during the latter stages of their training and the transition into work was role ambiguity resulting from the lack of title other than Trainee Clinical Psychologist and lack of differentiation from 3-year trainees. It symbolises a lack of acknowledgement of their experience and of their different role. Effectively they are spending one or two years more to gain the same formal qualification as their 3-year peers. This situation appears untenable. Greater clarification and formalisation of flexible trainees' career pathway would be beneficial with regard to both professional and financial recognition.

Gaining appropriate financial recognition is a problem that many clinical psychologists currently face, within the context of Agenda for Change, and there is much uncertainty and inequity across the country. Within this context flexible trainees' position is also uncertain. 3-year trainees are paid on band 6 during their training and band 7 upon qualification. Some 3-year trainees obtain band 8 posts immediately after qualifying within certain health boards where there are no band 7 posts. Flexible trainees are

currently paid on band 6 for all 5 years of their training, leaving them financially disadvantaged in relation to their 3-year peers. This situation is under appeal with the aim of achieving band 7 for flexible trainees' 4th and 5th years.

Amicus the union (now Unite) and the British Psychological Society have proposed a preceptorship model to enable newly qualified clinical psychologists to consolidate their skills and develop specialist knowledge. Band 7 posts are considered transition posts and a vehicle for:

...affording the newly qualified clinical psychologist the opportunity to develop particular subsets of psychological skills and enhance a particular area of psychological knowledge that it would be impractical to imagine any training course delivering given the diversity of psychologists' applied NHS practice. (Amicus and the BPS, 2006, p.3)

This seems appropriate given the *reality shock* experienced by many newly qualified 3-year practitioners during this transition and their goals of consolidating their clinical skills in their first post-qualification year. Positive preceptor relationships have been found to reduce role conflict and role ambiguity amongst newly qualified nurses (Chang & Hancock, 2003). A more formalised expectation of this transitional period may therefore relieve some of the pressure on newly qualified practitioners to feel fully competent and knowledgeable on qualification.

The ambiguity surrounding the flexible trainee role means that there is uncertainty as to how they are viewed on qualification. They are still 'newly qualified' in many people's eyes, yet have one or two years extra experience within a particular specialty. It seems likely that 5-year flexible trainees' knowledge and skill base will be greater than their 4-year peers. The results of this study would suggest that flexible trainees have opportunities to consolidate and develop specialist skills, described within the preceptorship model, during their training. They appear more confident in assuming the wide range of roles of a clinical psychologist and identify more strongly with this role than their 3-year peers. It is therefore important that this experience is recognised

enabling 4-year flexible trainees to spend less time in transitional posts or to progress straight into band 8 posts in the case of 5-year flexible trainees. With many qualified clinical psychologists of several years experience still being paid on band 7 and much uncertainty regarding the outcome of the review of their posts, it is acknowledged that this could seem inequitable. However, if the profession's view of band 7 posts as transitional is upheld, then flexible trainees' role and salary progression should be formalised under the new system.

One aim of the preceptorship model is to allow newly qualified clinical psychologists to gain experience practicing independently. Whilst still receiving close supervision and support, newly qualified clinical psychologists have clinical responsibility and authority in their new roles. Flexible trainees do not have such opportunities within their work role: all their work is countersigned as a result of their trainee status, which affects their status and relationships with other professionals. It would therefore seem important that flexible trainees, particularly in their 4th and 5th years, are able to practice to the same degree of independence as their 3-year peers (i.e. having a different title and clinical responsibility) in their work roles, whilst continuing to complete the rest of their training. This would provide greater eligibility for their progression on qualification and provide recognition of the level of knowledge and skill acquired in their work component during the first three years of training, reducing their sense of internal dissonance.

The Division of Clinical Psychology (DCP) has defined a set of competencies expected of qualified practitioners in the first two years of qualification. Incorporating these competencies into flexible trainees' work components would help evidence their level of knowledge and experience, gained over four or five years. This would be an important move towards differentiating flexible trainees from their 3-year peers and for formally recognising their experience, giving both them and their line managers a framework within which to structure their development as clinical psychologists.

In my opinion, running two training models simultaneously automatically creates conflict between the two groups of trainees. Exclusive endorsement of one model would improve the experience of all trainees. Many flexible trainees describe feeling as though the course is still largely organised around the 3-year model and view some of the adaptations made for flexible training as unsatisfactory. They seem to struggle most with attending academic teaching blocks with different years. During their latter years particularly, they feel that the content is not sufficiently adapted to accommodate the range of experience and describe finding lectures too basic given their level of knowledge. They feel that they have already accrued a great deal of knowledge through their work and private reading by the time they access core placement lectures. Whilst this system has been adopted to maximise congruence between teaching and placements, flexible trainees seem to find it unsatisfactory. One possible solution is for trainees to complete their teaching as a cohort, spending a greater proportion of their time on teaching during the early years of their training. In their 4th and 5th years they could continue to attend more specialist teaching sessions, with 3-year newly qualified clinical psychologists, aimed at developing the DCP competencies alongside their peers, thus promoting greater equality with regards to their professional development and fostering better integration of theory and practice⁷. Such a programme could also help to reduce the conflict that arises from the trainee professional course's location within the university setting (Jackson, 1970) that is heightened in flexible trainees' 4th and 5th years.

Agazarian and Gantt (1997) state that systems' ability to discriminate and integrate difference, determine their survival. Therefore if both models continue to run alongside each other, better integration within the training programme would be beneficial as would differentiation of the flexible trainee role and career pathway.

⁷ This was a suggestion made by my head of department some time ago regarding 'professional issues teaching' and to which I initially reacted negatively. However, on reflection and consideration of the findings of this study it would appear to have a number of advantages.

3) Facilitating appropriate opportunities for responsibility, autonomy and inclusion during training.

The work component can provide opportunities for greater autonomy, responsibility and inclusion. It is important that flexible trainees have such opportunities so that their development reflects that of their 3-year peers. Greater clarity regarding the flexible trainee role, particularly in their 4th and 5th years is therefore important. Working towards the DCP competencies for newly qualified clinical psychologists could be a useful guide and attending the same teaching and development sessions as their newly qualified 3-year peers would validate their level of experience and help reduce inequalities in status. Accompanied by formal recognition in the form of a different title, flexible trainees could perhaps develop equilibrium in the latter stages of their training. It would also protect against the negative consequences experienced by trainees who are not afforded sufficient opportunities for responsibility and autonomy in their work components.

Hecht (2001) found that less flexibility and thus limited choice within work was associated with greater feelings of role conflict amongst working mothers. Flexibility between the three different roles that flexible trainees have could help to reduce the conflicts that they experience. Where there is person-role conflict a degree of flexibility in trainees' work component specialties would be beneficial for trainees and the organisation. Person-role conflict can result in loss of self-esteem, decreased job satisfaction, loss of motivation and deterioration of social relations which can have knock on effects for the effectiveness of the organisation (Kahn *et al.* 1964; Ortquist & Wincent, 2006). If there is conflict between individuals' area of interest in psychology and their work component, they are less likely to invest in this role, reducing their productivity and potentially impeding their developing competence. Individuals are unlikely to seek employment post-qualification in a work component specialty they dislike. This could have implications for both career and pay progression, particularly within a preceptorship model. It would therefore seem appropriate in such circumstances for flexible trainees to change their work component to more closely

reflect their interests, wherever possible. It is acknowledged that this might be difficult, however it is likely to be beneficial for both the service and the trainee.

4) Increased integration of theory and practice

There is some evidence to suggest that flexible training provides greater opportunities for the integration of research and clinical roles, arguably an advantage of this model. It could be hypothesised that on qualification these clinical psychologists may be better able or better motivated to continue to integrate these two roles, reflecting greater application of the scientist-practitioner model. However, it is likely that they will face the same time pressures described by clinical psychologists as the main barrier to engaging in research (Kennedy & Llewelyn, 2001) and this is perhaps a wider issue within the profession.

The introduction of more formalised reflective practice on personal and professional development might also help trainees to integrate theory and practice, as might reducing the role conflict between trainees' student and trainee professional roles.

4.4 Methodological considerations and future research directions

The design of this study was constrained by time and resources. The original intention to sample a cross-section of trainees in years two to five, collecting data from the 2004 and 2005 cohorts, was beyond the scope of this thesis. It was only possible to sample 4-year flexible trainees' transition to qualified practice as the first cohort of 5-year trainees graduate in September 2008, after submission of this thesis. Inclusion of 5-year trainees' transition to qualified practice would further enhance understanding of the impact of the flexible training scheme on professional identity development. I was only able to sample four flexible trainees' transition to qualified practice. Although differences in experience were described in this group further investigation of this transition is warranted amongst both 4 and 5-year flexible trainees.

In order to minimise the disadvantages of being the sole investigator involved in this study and to enhance validity, I paid particular attention to incorporating a number of other forms of triangulation (section 3.2.2) including: triangulation with the existing literature, respondent validation and independent audit.

I have discussed the implications of my role as a trainee in previous sections. Whilst this presented some challenges, my close relationship with the research topic and with the participants increased my awareness of the potential impact that my own experience, and assumptions based on this, could have on the research process. In many ways I feel that this position has helped me to attend rigorously to issues of reflexivity through a high level of transparency and consideration of both the personal and wider contexts in which this research is situated. The reader is then in a position to judge my interpretations with this knowledge in mind.

Interesting areas for further investigation include:

- 5-year flexible trainees' transition to qualified practice in comparison with 4-year flexible trainees.
- The impact of 3-year trainees' experience of competing for jobs and working alongside 4 and 5-year flexible trainees on their transition to qualified practice and their professional identity development.
- A comparison of subsequent flexible trainee cohorts' experiences with the first cohort's. The first cohort's experience was greatly influenced by rapid developments within the training program which, in turn, were influenced by the wider social and political context of the profession. A comparison of subsequent cohorts of flexible trainees would enable tentative conclusions to be drawn about factors within the model of training that impact on professional identity development and those that are a product of the interaction between this model and the specific context in which this particular cohort was situated.

- A comparison of flexible and 3-year trainees' attitudes towards research and their research productivity on qualification.
- An exploration of the Course staff, NHS managers and supervisors' experiences of the flexible training programme. This would add further depth to my understanding of the process of professional identity development and would be important when considering the feasibility of different possibilities for addressing the issues identified, from the trainees' perspective.

4.5 Concluding Remarks

This research has been an enjoyable and enlightening process, personally and professionally. I believe that my understanding of professional identity development has been enhanced by this process. Hearing other people's experience has helped me to understand the factors that are important to developing a sense of professional identity from both flexible and 3-year trainees' perspectives and to make sense of the times that I have struggled with this. I hope that it will continue to inform my evolving professional identity and my own practice when supervising trainees in the future. I hope that I can remain interested in and mindful of the experiences of others, and engage in and provide opportunities for reflection, which are invaluable in making sense of experience.

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Appendix 1: Invitation to Participate

The impact of the flexible and full-time training models on the development of professional identity.

Dear everyone,

I'm writing to request your help in the form of participation in my Clinical Psychology Doctoral thesis. This is a development of the pilot study I conducted in 2005, in which some of you kindly participated, and which yielded some interesting data.

I am planning to conduct a number of focus groups and individual interviews with trainees to explore the impact that the flexible model has on the trainee's experience in comparison with the 3-year model of clinical psychology training. I am interested in exploring issues relating to professional development such as mastery of skills and professional socialisation and the transition from trainee to qualified practitioner of both flexible and full-time trainees. I aim to identify important themes that emerge from your experiences related to the different aspects of the training process.

All of your views and experiences are important to the development of a deeper understanding of the above issues and I would be extremely grateful if you would be willing to share them. This would involve participation in a focus group with other trainees from your year group or a one-to one interview with myself if you prefer, to discuss your experiences.

As your experiences are likely to change over time and at different stages of your training I would like to collect some longitudinal data to better understand the process of the development of professional identity. I therefore ask if you would be willing to participate in a second focus group or interview approximately 1 year after the first, although you are of course free to opt in or out at any time.

What would my participation involve?

- Participation in 1 or 2 group or individual interviews lasting approximately 1 to 1 ½ hours. One would take place in 2007 and the other in 2008.
- I plan to conduct the interviews in the Clinical Psychology Department at the University of Edinburgh at times that are suitable for you (most likely during teaching). If it is more convenient to you I can arrange to conduct some interviews at your health board bases. These arrangements will be finalised nearer the time but my aim is to make their location and time convenient to you.
- You are free to participate in either one of the interviews, both of the interviews, or, of course, none of the interviews.

- I may wish to follow up specific areas of interest and importance that emerge from the interviews in more detail. I may therefore invite some participants to take part in a further semi-structured interview which you are free to accept or decline without explanation.
- Your participation is entirely voluntary and is in no way connected to, or a requirement of your training.
- You are free to opt in or out of the study at any time.

What will happen to the data?

- All the group and individual interviews will be transcribed and the anonymised transcripts will be seen only by myself and my academic supervisor, Dr Matthias Schwannauer, for the purpose of supervision. The information will be kept confidential.
- Digital recordings will be destroyed following transcription.
- All data will be reported anonymously and any identifying information will be omitted.
- The transcripts will be analysed thematically using a grounded theory approach.
- Following the analysis I will provide feedback of the main issues to emerge from the interviews and invite you to comment.
- The final results will be published as my doctoral thesis and I will also provide you with a summary of the main findings. I plan to make the results available to other professionals or stakeholders who may be interested in the findings.

Why participate?

I think this is a great opportunity to explore some of the issues raised by the changes occurring in the training experience at present from the perspective of trainees. It is my aim, with your help, to shed some light on the relative merits of the two different models of training (in terms of their impact on the development of professional identity) and to potentially inform future developments through wider dissemination. Although you may not personally experience any beneficial outcome of potential future developments I hope that you find the experience an enjoyable one.

What do I do now?

If you would like to participate I would be extremely grateful if you could reply to me by e-mail, phone or in writing and complete the attached form. I have arranged some slots for group discussions on 19th and 20th February when we are in teaching. If you are interested in taking part, please let me know which times you prefer or those that suit you best.

If you have any questions regarding this research project I would be happy to discuss them with you. My contact details are below:

Rowena McElhinney
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01383 565402

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Thank you for your time and consideration.

Yours faithfully

Rowena McElhinney
Trainee Clinical Psychologist

Appendix 2: Guided Reflection on Graduation Experiences

Reflections on the graduation of the 4 year flexible trainees and the 2004 full-time cohort on Tuesday 27th November 2007.

I would greatly appreciate you taking a few minutes to reflect on your experiences of the above event. I would really like to hear from you whatever your experiences. Even if the event was not significant for you I'd appreciate if you could answer the questions as best you can.

1) Please indicate your training model:

3 year 4 year 5 year

2) Did you receive an invitation to the recent graduation breakfast celebration in the Clinical Psychology Department at the University?

Yes No

3) Did you attend this event?

Yes No

4) Did you attend the Graduation Ceremony?

Yes No

5) Please reflect on your reasons for attending or not attending these events?

6) What kind of thoughts and feelings did this day / event evoke for you? Was it an important day for you? In what way? What was your experience of it?

7) What specific situations, events or interactions have influenced your thoughts and feelings about the event?

8) How did this day and the thoughts and feelings it evoked compare to last years graduation event for the full-time trainees in our cohort?

9) Do you have any further comments or reflections?

Appendix 3: Example of Transcript Coding

Participant A7: I think identity is a bit confused (uh huh) cos we're not trainees and we're not qualified so.

not trainee -
not qualified
confused
conflict in role
ambiguity
no clear role
no clear identity

Participant A8: we don't have one (yeah)

Participant A9: Yeah, that was my initial reaction (yep). But also that I feel I've got more of a personal identity of who I am in the profession but that's not acknowledged by the profession because we don't have a title and we don't have a role and we don't, I kind of think in my head who I am or who I should be but. (r: ok)

not acknowledged by
profession
lack of recognition
lack of title
no clear role
personal feelings
formal recognition

Participant A8: I kind of feel that I've put it on hold thinking that well I know who I'll be when I finish (umm) but at the moment it's like well.

identity on hold
role ambiguity

R: What's your kind of personal identity then of who you are in the profession?

Participant A9: I suppose um, I'm, when I'm in my work component, I feel less of a trainee and more of somebody that's working (umm) and managing, you know, case loads and er, waiting lists and seeing patients and going day to day, but and then, every now and again you get reminded that you're not completely autonomous, that you're still supervised, that you don't have full responsibility that you are a trainee or a student. (Student.) So I think, you know, it's kind of, I feel in some ways, I feel I am qualified (umm) like I do some qualified stuff but just I don't have qualified title so therefore.

work component
identity
not trainee / a worker
qualified tasks
opportunity to assume
another role
reminder of trainee
status
autonomy
supervision
responsibility
trainee / student status
feel qualified
lack of title
role conflict

Participant A10: I think things for me have changed for the better recently. A newly qualified member of staff has just joined the department. And I know that I

comparisons to
others
no impact

know more than she does about certain tests and doing certain assessments and what the protocols and procedures would be. So I've started to feel less junior than I did say this time last year. But junior none the less, I think, and still I don't have the d r in front of my name. (uh huh, yeah, yeah)

competence
know more
- status
- less junior
- still junior
role ambiguity
lack of title

Participant A8: I've had that experience but it's kind of, it's more, if anything it's kind of making things worse (umm). Cos I think, I know more about it, I can do the job standing on my head. Here I am, stuck. (umm, umm) and that's what you think and it just kind of makes me feel quite, it's hard to get motivated (umm; r: uh huh) just to do things like on a day to day basis. It's really hard./

competence & others
- we report
competence
stuck
motivation
doing minimum

R: /and in what way stuck?

Participant A8: stuck because, well ok an example of a qualified person starting who was in our year, teaching her what tests she should do. and then, the thing that pops into your head is, here I am stuck on, can't move, eh well you can't move anywhere, (umm) you've no freedom. Money wise she's earning a third more than me (r: uh huh). I'm getting my letters checked for grammar. (laughter) Do you know, (r: yeah) and it, what that does is it makes you feel less confident and kind of you know, well that's it for me. Even though you know you're confident yourself. You're competent at what you can do. (r: uh huh).

competence & others
competence
stuck
lack of freedom
autonomy
lack of recognition
pay
closely supervised
compet ability +
status
confidence

Participant A11: I think my work component has been really, really important to me throughout the whole of this. Um I've, I've kind of said this, probably about 6 months ago, that I've always felt more part of my department than I have a trainee, as part of a year cohort. (r: yeah) um but I think more recently, I feel I'm being pulled back into the trainee role because I've gone into a specialist placement that I don't really have any experience in, and so I don't have as much autonomy, and I am feeling more unsettled than probably I have throughout the whole, you know the whole of the training. But that's kind of been about me, and wanting to

importance of work
identification
department
role conflict
motivation
placements render
of trainee status
lack of confidence
lack of autonomy
changing identity
conflict work training

challenge myself and wanting to do something different, so I've kind of brought it on myself.

Active choice

R: and so I guess, so that's just in your new placement then that you feel that you've kind of, almost like you got quite comfortable in your work, felt much more part of the department, feeling quite comfortable in the roles that you were doing but then kind of doing something new has kind of taken you back. Is that what you mean? (yeah)

Participant A9: It's like, we did our core placement in [specialty] in 3rd year and that was quite funny cos you know been quite confident you know, everything was going well and then suddenly you're back to basics going wuuh. And they didn't match the two days of the week didn't match (um I know what you mean) do you see kind of and you might do two, more in your core placement cos you just assume.

*confident, competence
back - to basics
infact not +
being
do more
Sub transfer to
placement*

Participant A10: half expecting my 5th year to be um, eh less of a good experience than this year has been because, because I'm in the same department 4 days a week doing my placement and my work component, and I think everyone knows me and what I'm doing and where I'm at, whereas next year I'll feel like more of a trainee again going to do my [core placement] (yeah, that's exactly it)

*expectations
integration with
placement
relationships + colleagues
role definition
trainee status*

R: so because you're in, in, at the moment then is there much differentiation between your work and placement?

Participant A10: Not really, no. um in the type of work I do my placement is in [area of specialty] but my work is in [different area of specialty]. So I have different supervisors but all within the same department. And the department's quite tight, and we all see each other really regularly. (r: uh huh) Um and I've spent the last 2 and a half years explaining what I am (r: yeah) and I spent the first

*integration of
work + placement
inclusion
know colleagues
see regularly
defining role*

year saying I'm not an assistant psychologist and I think everyone's been pretty decent with that.

slowing expectation
of others.
status.

R: And how do others perceive you in the department?

Participant A10: fine I think I'm just another member of the team really. I guess I get more aware of feeling junior when I go onto the ward on my own. It's somewhere that I've not been that regularly. (r: uh huh) Having seen a lot of outpatients and then you go to the ward and see a lot of inpatients, and feeling a bit more, I don't really know where I'm going or who I'm supposed to be seeing or what the procedure is. (r: uh huh)

member of
team
feeling junior
status
influence of context
particularly
aware of role
ambiguity
lacking confidence

R: What do other people think about um, you know, other people's perceptions of them.

Participant A7: Other people's perceptions of us? (r: yeah, of you as, in your role) psychology students.

attitudes of
others
student status

Participant A8: In my team I got treated the same as the as the A grades. There was a presentation to be given, (r: uh huh) then I gave it. (r: yeah) You know, but I never had, but then it just kind of flips back to my first point you know (umm) and I sit and think (I think there's/) /I think oh you know they must value me they must think, but then on the other hand I think well if you value me that much you know, . . I wouldn't still be a flexi trainee with a year and a half to go (laughs). That's what you think. That's what comes into my head. All the time.

treated as
qualified
inclusion
responsibility
role conflict
ability + status
value
carrying stuff
to others
extra years
train + recognition

Participant A9: one thing I feel, that I don't, it's not necessarily that I know how, what they think of me, whether I'm a student or whether I'm qualified, but when you have somebody that remembers you and knows who you are, then you kind of remember that they do know you've been around a long time. (umm; r: uh huh)

uncertainty re
how viewed.
people know your
relationships to
colleagues

And that's quite nice when you have somebody that maybe you haven't seen that, or you saw a while ago in another patient and then you see them again. And then they see you more as a permanent feature rather than and that feels good too. (I think that's, I'd agree with that yeah) rather than another trainee appearing and (yeah).

working relationships
permanent feature
positive impact
comparison & trainee role

Participant A11: I think it's interesting that we talked about advocacy in the training that we've done in the last couple of days because I think people have advocated for me a lot, in both the roles. Both in work and, you know even in this new situation where I'm on placement, my supervisor has kind of made it quite clear what my role is and that, you know, I do have, you know, nearly 4 years experience. Um and in work, the flexible trainees are kind of all together so it's about us being different. A different thing from a normal trainee, (r: uh huh) or another trainee (wow) which is really, really helpful. (r: yep) And it's nice to have that forum to be able to discuss what it, you know what being a flexible trainee is.

advocacy
attitudes towards
flexi
attitudes of others
clear role
acknowledgement of experience
differentiation of role
comparison & trainee role
positive impact
open communication
not normal trainee
new self-identity

R: and in what way has that been helpful?

Participant A11: I guess because it distinguishes us. You know, we are more of a permanent feature and we, you know, it kind of makes us feel like we're a different kind of group and . . Yeah. It kind of highlights that we are being treated differently.

differentiation of role
permanent feature
treated differently
comparison & trainee role

Participant A9: I think that's really important. And that sounds great that you've got that because I feel I've all the positives about being a flexi i.e. more responsibility, being in the department, people know me, all that, but yet I'm still not viewed as something different from a trainee who's just been there a long time. (umm)

positives of flexi
responsibility
inclusion
known by colleagues
not viewed differently
comparison & trainee
status
role conflict ability
+ status
lack title

R: by people in the department or?

Participant A9: yeah. I mean I, one of the biggest bug bears is I've always been on the, they would have a diary and everybody has columns and down at the bottom they squeeze in the trainees (r: right) and I've always, always been down with the trainees (umm) even after 3 years. /

attitudes of others
created as trainee
not differentiated
status
value

Participant A8: / things like the name badge. You know. Cos see when you introduce yourself you've got to introduce yourself as a trainee clinical psychologist because that's what you are (r: yeah). And they can give it all the, you know, you're different and that but at the end of the day nobody's really went, you know, hell for leather to say lets give these people a new job title and we're going to push it because it's just been going on at a snails pace. (r: umm) Cos they've had 4 years now. (yeah)

little
status
working relationships
trainee status
lack of differentiation
lack of support
lack of title
slow to develop

Appendix 4: Example of Category Development: Summary Table of the Different Levels of Coding within one Category

conflict between ability and status	transition to newly qualified	more responsibility	comparison to trainee	buck stops with you
				clinical responsibility
				managing risk
				service development
		not what expected	aims and expectations	honeymoon period
				build skills
				build confidence
			reality	steep learning curve
				unprepared
				all or nothing
		lacking confidence	feel deskilled	lack experience and knowledge
				expectations of self
			conscious effort to act qualified	positioning self with assistants feel more qualified
				more in common with trainees
	split self	feel qualified	competence	extra experience
				confidence
				comparisons with 3-year
			treated as qualified	qualified tasks
				autonomy
			value	included
				contribution
				others' acknowledgement
		you are who you are	not autonomous	too closely supervised
				restricted
			still training	being assessed
				trainee and student status
			lack qualified title	clear divide –feel junior
				nothing to distinguish

Appendix 5: 'Conflicts' Interview Guide

1. Conflict between ability and status

- Does this occur in response to comparisons with newly qualified peers
- Are there other circumstances in which this occurs
- What factors affect this – can you think of an example
- What factors exacerbate or ameliorate this feeling / conflict
- Are there trainees who do not feel this conflict?
- Why might this be, what is different about their experience?
- What is the impact of this?
- How do trainees cope with / manage this conflict?

2. Conflict between personal and professional

- In what way is there conflict between their personal life and their professional role / situation? Where does this conflict come from? What factors affect this? What is the impact of this? How do trainees cope with/manage this conflict?
- When there is a conflict between the trainees' personal interests and their professional role, under what circumstances does this conflict arise? Where does this conflict come from? What exacerbates it or ameliorates it? What is the impact of this? How do trainees cope with/manage this conflict?
- What is the effect when no such conflict occurs? Is it the case that if the trainees' personal area of interest matches their work component there is less conflict between their personal and professional lives?

3. Conflict between work and training

- Under what circumstances does this conflict arise?
- What factors exacerbate/ ameliorate it?
- What is the impact of this?
- How do trainees cope with/manage this conflict?
- What competing demands exist for trainees?
- Where do these demands come from?
- How do they cope with these demands?
- What is the impact of these demands?
- What is the impact of trainees desire to be working?
- Where does this stem from?
- What conflicts does this then create for trainees?
- How do they manage these?
- What is the effect of the trainee favouring their work component?
- Why do they favour one or the other? What is it about that, that they prefer?
- How does this impact on the other and their academic component?
- What is the effect of the trainee favouring their placement?

- How does this impact on their work component and academic components?
- What are their priorities?
- What are trainees' sense of commitment to their work component?
- Do they feel more committed / obligated to their work, to their employing department / manager to their placement supervisor?
- What is the effect of this?
- Where do they think this comes from? What factors affect this?
- Can they provide any examples of this?
- How does this impact on their development – personal and professional?

**Appendix 6: Confirmation from NHS Fife Ethics Committee and The
University of Edinburgh Regarding Ethical Review.**

Page 1 of 1

McElhinney, Rowena

From: Thow, Fiona [Fiona.Thow@faht.scot.nhs.uk]
Sent: 04 July 2006 09:49
To: rowenamcelhinney@fife-pct.scot.nhs.uk
Subject: Research Proposal

Rowena,

Further to your email to Janice Millar on 30 June 2006, we passed on the information to Mr Buchan who has looked at it and has said, thank you for your protocol. I now consider that ethical review is not required for this study.

Robert Buchan
Chair
Fife & Forth Valley LREC

Fiona Thow
Clerical Officer
Corporate Services
Hayfield House
Tel: 01592 643355 Ext: 8977
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McElhinney, Rowena

From: Karen McKenzie [drkmckenzie@hotmail.com]
Sent: 12 July 2006 17:48
To: McElhinney, Rowena
Subject: Ethics approval

Hi Rowena,
Someone else may already have contacted you in relation to this...but I was copied in to the correspondence as Ken is away at present and I thought you'd want to know as soon as possible. The upshot of your query (passed on from Mick/Kath) is that you should put your proposal through the NHS ethics committee as the trainees are all NHS employees and the ethics structure within the university for trainees is not finalised yet.
I hope this helps.
Best wishes
Karen

McElhinney, Rowena

From: Michael Power [mjpower@staffmail.ed.ac.uk]
Sent: 19 July 2006 15:51
To: McElhinney, Rowena
Subject: RE: Ethical approval

Hi Rowena,

I can confirm on behalf of myself and Kath Melia, Head of School, that it would be appropriate to refer your study to an NHS Ethics Committee.
A copy of your email correspondence with the Chair of the Committee should therefore be included in the Appendix of your thesis.

With best wishes,
Mick.

Appendix 7: Management Approval from NHS Fife



Ms Rowenna McElhinney
Psychology Dept
Lynebank Hospital
DUNFERMLINE

Medical Director, Primary Care
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Date 10 January 2007
Your Ref
Our Ref N/A 68
Enquiries to Aileen Yell
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Dear Ms McElhinney

Project Title: The Impact of Flexible Training on the Development of Professional Identity

Thank you for your application to carry out the above project.

Your project documentation has been reviewed for resource and financial implications for NHS Fife Primary Care Division and I am happy to inform you that Management Approval has been granted. I note that ethical review has been deemed unnecessary in this case.

Details of our participation in this study will be included in quarterly returns to the National Research Register and annual returns we are expected to complete as part of our agreement with the Chief Scientist Office. The enclosed Research Registration Form has been prepared and should be checked, signed and returned together with the attached NRR Form to the R&D Office, Lynebank Hospital, Halbeath Rd, Dunfermline KY11 4UW. If you have any questions or need further information contact Amanda Wood, Research Coordinator on: 01383 623623 ext 5111 or at amanda.wood@faht.scot.nhs.uk

May I take this opportunity to remind you that all research undertaken in NHS Fife is managed strictly in accordance with the Research Governance Framework for Health & Community Care (<http://www.sehd.scot.nhs.uk/cso/>) and that all research should be carried out according to Good Clinical Practice (GCP). In order to comply with the RGF, the R&D Office are required to hold copies of all study protocols, ethical approvals and amendments for the duration of this study.

You will also be required to provide information in regard to monitoring and study outcomes, including a lay summary on completion of the research. I would like to wish you every success with your study and look forward to receiving a summary of the findings for dissemination once the project is complete.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Stella Clark'.

DR STELLA CLARK
Medical Director, Primary Care
NHS Fife

Cc : Aileen Yell, Asst R&D Co-ordinator, NHS Fife, Lynebank Hospital, Dunfermline